

**UNITED STATES DISTRICT COURT**  
**DISTRICT OF MASSACHUSETTS**  
**SPRINGFIELD DIVISION**

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SEXUAL MINORITIES UGANDA

Civil Action

3:12-CV-30051 (MAP)

*Plaintiff,*

v.

SCOTT LIVELY, individually and as President  
of Abiding Truth Ministries

*Defendant.*

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**EXPERT REPORT OF DR. ILAN H. MEYER**

I have been retained by the Center for Constitutional Rights to provide written opinion and possible live testimony as an expert witness on behalf of Plaintiff Sexual Minorities Uganda (“Plaintiff”) in connection with the pending action entitled *Sexual Minorities Uganda v. Scott Lively*, U.S. District Court, District of Massachusetts, No. 3:12-cv-30051 and any related litigation.

My work for this report is provided *pro bono*. I am not being compensated for research and the writing of this report. However, Plaintiff is reimbursing me for all reasonable and necessary out-of-pocket expenses incurred in relation to this work, including expenses related to any travel that would be necessary related to my work in this case. In addition, in the event Plaintiff or its counsel recovers attorneys’ fees or costs in this action and/or any related litigation, Plaintiff or its counsel will compensate me at an hourly rate of \$250.00 per hour. Reimbursement of my expenses or other compensation is not in any way conditioned upon or affected by either the substantive results or conclusions of my work, or by the final outcome of this action.

### **I. Qualifications**

I am the Williams Distinguished Senior Scholar of Public Policy at the Williams Institute at the University of California Los Angeles (UCLA) School of Law in Los Angeles, California. The Williams Institute’s website describes its mission as follows:

“The Williams Institute is dedicated to conducting rigorous, independent research on sexual orientation and gender identity law and public policy. A national think tank at UCLA Law, the Williams Institute produces high-quality research with real-world relevance and disseminates it to judges, legislators, policymakers, media and the public.

Experts at the Williams Institute have authored dozens of public policy studies and law review articles, filed amicus briefs in key court cases, provided expert testimony at legislative hearings, been widely cited in the national media, and trained thousands of lawyers, judges and members of the public.” “The Williams Institute is committed to the highest standards of independent inquiry, academic excellence and rigor. Research findings and conclusions are never altered to accommodate other interests, including those of funders, other organizations, or government bodies and officials.”

(<http://williamsinstitute.law.ucla.edu/mission/#sthash.9qcEVulh.dpuf>).

Prior to arriving at the Williams Institute, from July 1994 until June 2011, I served in different roles at Columbia University in New York City. My last position there was as Professor of Clinical Sociomedical Sciences and Deputy Chair for Masters Programs in Sociomedical Sciences at Columbia University’s Mailman School of Public Health.

My area of expertise is the study of the effects of social stress related to prejudice and discrimination on the health of lesbian, gay, bisexual and Transgender (LGBT) populations. This area of study belongs to an area of study called *social epidemiology*. Social epidemiology is concerned with social patterns of disease and risks for disease. “Social epidemiology is about how society’s innumerable social arrangements, past and present, yield differential exposures and thus differences in health outcomes . . . .” (Oakes & Kaufman, 2006, p. 3).

My original theoretical and empirical research focuses on the relationships among stigma and prejudice, minority social status and identity, and mental health and well-being. I have studied, in particular, United States populations defined by sexual orientation (lesbian, gay, bisexual, and heterosexual), gender (men, women, transgender), and race/ethnicity (African Americans, Latinos, and Whites). Through these studies, which use methodologies widely -

accepted in the field of social epidemiology, I have developed a model of social stress referred to as *minority stress* (Meyer, 1995; Meyer, 2003). This model has become the most prominent and commonly used framework for the study of health disparities in LGB individuals (Herek & Garnets, 2007; IOM, 2011) and has generated hundreds of scientific papers by many scientists. For this work, I have received several awards and prizes including the American Psychological Association Division 44 Distinguished Scientific Contribution Award.

I received my Ph.D. in Sociomedical Sciences and Social Psychology from Columbia University's Mailman School of Public Health in 1993. My doctoral dissertation, titled *Prejudice and pride: Minority stress and mental health in gay men*, received distinguished designation, awarded to the top 10% of Columbia University doctoral dissertations, as well as the Marisa De Castro Benton Dissertation Award for outstanding contribution to the sociomedical sciences, and an honorable mention from the mental health section of the American Sociological Association's award for best dissertation. Prior to graduating, I was a pre-doctoral National Institute of Mental Health Fellow in Psychiatric Epidemiology at Columbia University from 1987 to 1992. Later, I was a National Institute of Mental Health Research postdoctoral fellow in health psychology at The Graduate Center at The City University of New York from 1993 to 1995 and a National Institute of Mental Health Research postdoctoral fellow in psychiatry, with a focus on acquired immune deficiency syndrome (AIDS), at Memorial Sloan-Kettering Cancer Center from 1995 to 1996. I returned to Columbia University's Mailman School of Public Health in 1994 and served as an Assistant Professor of Clinical Public Health. In 1998, I was appointed an Assistant Professor of Public Health in the Department of Sociomedical Sciences. I was appointed as an Associate Professor of Clinical Sociomedical Sciences in 2003, Deputy Chair for Masters Programs in the Department of Sociomedical Sciences in 2004, and Professor

in 2010. From 2006 to 2007, I was a Visiting Scholar at the Russell Sage Foundation, a research center devoted to the social sciences in New York City. Further information regarding about my background and experience, as well as a list of my publications, can be found in my *curriculum vitae*, which is attached as Exhibit A to this report.

As reflected in my *curriculum vitae* (Exhibit A), I have published over 80 original, peer-reviewed articles, chapters, reviews, and editorials in scholarly journals and books. I have also co-edited a book, published in 2007 by Springer, titled *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations*, and three special issues of academic journals on these topics, including the first special issue of the *American Journal of Public Health*, published by the American Public Health Association in 2001 and, most recently, a special issue of *Psychology of Sexual Orientation and Gender Diversity* published by the American Psychological Association in 2015. I have made numerous presentations and invited addresses at professional conferences and meetings. I have received grants for my research from federal, state, and private funders. Currently, I am the Principal Investigator of a National Institutes of Health-funded study of stress, identity, and health among LGBT populations in the United States.

Among other professional activities, I currently serve on the editorial boards of the scientific journals *LGBT Health* and *Psychology of Sexual Orientation and Gender Diversity*. Over the past 15 years, I have served on editorial boards (e.g., the *Journal of Health and Social Behavior*) and reviewed, as *ad hoc* reviewer, numerous manuscripts for many of the top scientific and professional journals in the fields of public health, psychology, sociology, and medicine. From 1993 to 2002, I served as co-chair of the Science Committee of Division 44 of the American Psychological Association, the Society for the Psychological Study of Lesbian,

Gay, Bisexual and Transgender Issues. From 2000 to 2001, I served as Guest Editor for the *American Journal of Public Health*'s Special Issue on LGBT health, published in June 2001. In 2004, I served as Leader of the Working Group on Stigma, Prejudice and Discrimination for The Robert Wood Johnson Health and Society Scholars Program at Columbia University's Mailman School of Public Health. In 2006, I served as co-editor of the *Social Science & Medicine* Special Issue on prejudice, stigma, and discrimination in health, published in 2008. From 2012 to 2013, I have served as Leader of the Working Group on Sexual and Gender Identity (Who Is Gay?) at the Williams Institute, UCLA School of Law. From 2014 to 2015, I served as the guest editor for a special issue on resilience in LGBT populations that was published by *Psychology of Sexual Orientation and Gender Diversity*.

At Columbia University's Mailman School of Public Health, I taught graduate-level courses on research methods; stigma, prejudice, and discrimination; and sexual and gender minority (*i.e.*, LGBT) issues in public health. I have also taught other related topics in the past and continue to teach classes as a guest lecturer at UCLA and elsewhere (e.g., Fenway Summer Institute in Boston, MA; George Washington University, Washington, DC). As Deputy Chair for Masters Programs in the department of Sociomedical Sciences at Columbia University's Mailman School of Public Health, I led faculty in administering the MPH and MS programs in public health at our department. We admitted about 100 students per year for the 2-year program. I was responsible for about 200 students' entire tenure at the department, including their admission, academic performance, and graduation.

In the past five years, I have served as an expert either at trial or hearings or through declaration in:

- Expert witness testimony in *Perry v. Schwarzenegger*, 704 F. Supp.2d 921 (N.D. Cal. 2010).

- Expert report – Written testimony in application for asylum, withholding of removal, and/or withholding under the Convention Against Torture. Removal proceedings before Immigration Judge, United States Department of Justice, Executive Office for Immigration Review (2010).

- Expert testimony before the United States Commission on Civil Rights briefing on peer-to-peer violence and bullying in K-12 public schools (2011).

- Expert report – Written testimony in hearing before Immigration Judge on the validity of asylum granted to a bisexual man, United States Department of Justice, Executive Office for Immigration Review (2012).

- Expert report – *Charles Patrick Pratt, et al. vs. Indian River Central School District; Indian River Central School District Board of Education* (2013). Case settled prior to trial.

- Expert report – *Garden State Equality v. Doe*, Superior Court of New Jersey, MER L-1729-11 (2013).

- Expert witness – *U.S. v. Gary Douglas Watland*, Defendant. Criminal Action No. 1:11-cr-00038-JLK-CBS (2014).

- Expert report – *Bayev v. Russia* submitted to the European Court of Human Rights (2014).

## **II. Methodology**

I have been asked by counsel for Plaintiff to provide an opinion about the impact of the social environment on the health and well-being of LGBT individuals in Uganda. In preparing to write this report I was provided documents to review by counsel for Plaintiff (Exhibit B), including Plaintiff's First Amended Complaint (Case 3:12-cv-30051-MAP, Document 27, Filed 07/13/12).

If Plaintiff calls me to testify at trial as an expert witness, I currently expect that my testimony will relate to the topics discussed herein, including the study of stigma and prejudice that LGBT people face in Uganda, minority stress, and the effect of minority stress on the health and well-being of LGBT populations.

In connection with my anticipated testimony in this action, I may use this report or portions of it or the references cited herein as exhibits. In addition, I may use various documents produced in this case that refer or relate to the matters discussed in this report. I may also create, or assist in the creation of, demonstrative exhibits or summaries of my findings and opinions to assist me in testifying.

I may testify as an expert regarding additional matters, including (a) rebutting positions that the Defendant takes, including opinions of Defendant's experts and materials they discuss or rely upon; (b) addressing issues that arise from documents or other discovery that Defendant or other entities produce; or (c) responding to witness depositions and or testimony that has not yet been given or that I have not reviewed at the time of writing this report. I reserve the right to supplement or amend this report accordingly.

In this report, I rely on my reading and interpretation of current scientific peer-reviewed literature in different disciplines including, but not limited to, psychology, sociology, epidemiology, public health, and medicine. My analysis follows established social science rules of evidence. Social science evidence relies on the following: (a) theory, (b) hypotheses posed based on theory, (c) empirical evidence that assess these hypotheses using quantitative and qualitative methods, and (d) conventions and rules about causal inference developed in these disciplines over decades of methodological writings.

The scientific method allows for testing of theory-based hypotheses that can be nullified using statistical analysis and causal inference. Assessment of error is specific to the finding under study. Statistical analysis provides, in any test of hypotheses, estimates of the rate of error for some of the various ways that error can affect the results. For example, it can assess the impact of sampling error to inform the researcher of how precise a particular value is, such as a



population parameter (for example, the proportion of the population that holds a particular attitude). Other evaluations of error include, but are not limited to, assessments of the methods for sampling, for example, where potential biases can be assessed to understand whether the sample obtained by the researcher represents the population to which the researcher is generalizing his or her results.

Biases of various sorts bring about potential limitations in understanding research results. Because all studies have different methodological limitations, no one article or study is determinative. Indeed, a good scientific article should provide the reader with a thorough review of the study's limitations, as well as suggestions for further study that could address such limitations. The existence of methodological limitations in any one study, or even in a group of studies, does not by itself discredit a study, the area of investigation, or the conclusions that are drawn from this study or area of investigation. Relying on conventions of scientific research methodology and causal inference, a scientist uses his or her judgment about the significance and potential impact of the various limitations in any particular study or group of studies to form conclusions about the questions under study. For these reasons, like other scientists, I base my conclusions on an analysis of the cumulative evidence, a critical review of the theoretical basis for a study, the hypotheses tested, the methodology used, inference conventions and rules, and my years of experience as a researcher.

In choosing which literature to consult, I judge the quality of evidence, including, for example, but not exclusively, the type and prestige of the journal where a peer-reviewed article was published, the purpose of the article (e.g., review vs. original research), and the quality and rigor of the methodology used. My decisions about which scientific articles to review, how many scientific articles to consult, and what weight to give to any one scientific article were

based solely on scientific merit. In making these decisions, I relied on my experience and judgment about the best methods to assess the question under study.

In this report, I also rely upon media reports, witness accounts as reported by media or in social media (e.g., blogs) or other self-published media, and reports of governmental and nongovernmental organizations, such as the United Nations and Amnesty International. These sources are clearly referenced and provided in the list of references used (Exhibit C). As I reviewed such reports I attempted, to the best of my ability, to assess the veracity of the report based on the reputation of the source, cross validation from different sources, and my own assessment of the credibility and feasibility of the facts.

### **III. Definitions and Background**

#### **A. Homosexuality, Gender Roles, and Sexual Identity**

Homosexuality refers to a person's sexual orientation toward persons of the same gender, that is, an enduring pattern of romantic and/or sexual relationship with a person of the same gender, or the propensity for such romantic or sexual relationships.

Although in the past homosexuality was classified as a mental disorder, the American Psychiatric Association reversed this understanding of sexual orientation in 1973. To date, there is a consensus among physicians, psychiatrists, and social and behavioral scientists in Western societies and international organizations (such as the World Health Organization) that homosexuality is a normal and healthy variant of human sexuality.<sup>1</sup> Thus, for example, the

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1. See amicus brief of the American Psychological Association (In re Marriage Cases filed 9/07 California Supreme Court) "Homosexuality Is a Normal Expression of Human Sexuality" (Section II. B., p. 8) available at <http://www.apa.org/about/offices/ogc/amicus/marriage-cases.pdf>.

International Statistical Classification of Diseases and Related Health Problems, which is the most prevalent international classification system published by the World Health Organization, does not list homosexuality as a disorder even though it did so in the past. Similarly, a position statement on sexual and gender diversity adopted by the Psychological Society of South Africa's Council on 24 September 2013 noted "the recognition of LGB sexualities as normal and natural variances in that sexual diversity per se is not the cause of psychological difficulties or pathology" (Victor, Nel, Lynch, & Mbatha, 2014, p.295).

Three aspects of sexuality define sexual orientation: sexual behavior, sexual attraction, and sexual identity (Laumann, Gagnon, Michael, & Michaels, 1994). Sexual orientation based on *behavior* refers to the gender of the partner with whom a person has sexual relationships; *attraction* refers to the gender of the person toward whom one has sexual feelings and desires toward, whether or not they are expressed in any behavior; and sexual *identity* refers to the social identity a person has adopted to refer to their sexuality, such as, for example, whether a man uses the term *gay* to refer to himself. In general, people who have a non-heterosexual orientation in any of these dimensions are also referred to as *sexual minorities*.

There have been debates about whether the terms lesbian, gay, and bisexual (LGB) are Western-specific terms and whether they are fitting for discussion of sexual minorities in non-Western societies. For example, in Uganda, the term *kuchu* is used to describe some sexual minorities. For the purpose of clarity in this report I use the English-language terms, *lesbians*, *gay men*, and *bisexuals*, or *LGB*, to refer to sexual minorities, including Uganda's *kuchu*. My use of the Western terms in this report should not suggest that distinctions among cultures and culture-specific identities and terms are not important for any analysis. Rather, for the purpose of

this report, I use the terms in their broadest sense to indicate a non-heterosexual orientation, synonymous with culturally-specific terms.

Sexual orientation is different from other terms relating to sexuality, including *biological sex*—referring to whether a person is male or female—and *gender identity*—referring to whether a person identifies with the sex assigned at birth or a different sex (e.g., transgender). In most societies there are strongly-held convictions about the personality traits (e.g., aggressive, nurturing), appearance, and behaviors that characterize men and women. These are usually referred to as *gender roles*. There are strong social pressures to conform to socially-sanctioned gender roles. Although societies vary in gender role expectations and gender roles have changed historically, there is in general a tendency to view gender roles as natural and synonymous with biological sex. The view that gender roles are natural, and that they are synonymous with biological sex, imbues social conventions about gender presentation with moral and religious authority.

*Transgender* is an umbrella term used to describe individuals whose gender identity—sometimes referring to gender *expression* regardless of identity—is different from their sex assigned at birth (for example, a person living as a man whose sex at birth was assigned female).

*Transgender* refers to gender identity whereas *LGB* refers to sexual orientation. Therefore, a person who is transgender may be gay or straight (that is, heterosexual), and a gay person may be transgender or, more commonly, not transgender (also referred to as *cisgender*). Transgender is an identity that may or may not be claimed by a person regardless of his or her gender expression.

Sometimes concepts related to sexuality are confused by equating homosexuality (e.g., being a gay man, being attracted to a person of the same gender) with sex or gender (e.g., gay

men are women or women-like; Valdes, 1996). This has led to the conflation (and vilification) of LGB people and people who are gender non-conforming (i.e., a man who appears feminine regardless of his sexual orientation) and is a source of prejudice, stigma, discrimination, and violence toward LGB people in the United States and across the world (Wilets, 1996).

## **B. Stigma and Prejudice in Society and Law**

### ***1. Stigma is a fundamental cause of poor health outcomes.***

Stigma is a “fundamental social cause” of disease, which makes it “a central driver of morbidity and mortality at a population level.” Stigma is called a fundamental cause in that it “influences multiple disease outcomes through multiple risk factors among a substantial number of people.” Stigma leads to poor health outcomes by blocking resources “of money, knowledge, power, prestige, and beneficial social connections” (Hatzenbuehler, Phelan, & Link, 2013, p. 814), increasing social isolation and limiting social support, and increasing stress (Hatzenbuehler, Phelan, & Link, 2013).

Stigma is “a function of having an attribute that conveys a devalued social identity in a particular context” (Crocker, Major & Steele, 1998, p. 506). Stigma can be defined by these five characteristics: “In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics—to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of ‘us’ from ‘them.’ In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Finally, stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct

categories, and the full execution of disapproval, rejection, exclusion, and discrimination” (Link & Phalen, 2001, p. 367).

*Structural* (or *institutional*) stigma is “formed by sociopolitical forces and represents the policies of private and governmental institutions that restrict the opportunities of stigmatized groups” (Corrigan et al., 2005, in Herek, 2009, p. 67). Structural stigma restricts the liberty and dignity of members of a stigmatized group by erecting barriers to their success. One important function of stigma is that it legitimizes the unequal treatment of some groups in society.

“[P]eople of higher status may stigmatize those of lower status to justify [the higher status people’s] advantages” (Crocker, Major, & Steele, 1998, p. 509). When acted upon, antigay stigma is expressed as prejudice, discrimination, and violence against LGB people (Herek, 2009a, 2009b).

## ***2. Laws can propagate social stigma thus enhancing stigma through the stature of the law.***

Laws are perhaps the strongest of social structures that uphold and enforce stigma. “Law can . . . be a part of the problem by enforcing stigma” (Burris, 2006, p. 530). Laws can also eradicate and dismantle stigma. “Law can be a means of preventing or remedying the enactment of stigma as violence, discrimination, or other harm; it can be a medium through which stigma is created, enforced, or disputed; and it can play a role in structuring individual resistance to stigma” (Burris, 2006, p. 529).

Laws are often used to enhance a nation’s health. In using law to advance public health goals, public health officials and legislators consider the impact of the law on reducing, maintaining, or propagating stigma. From a social science perspective, irrespective of their legal functions or standing, laws both reflect and shape social values and attitudes and enhance or

diminish stigma. Indeed, the role of law in shaping stigma is so clear to public health professionals that they explicitly debate the ethics of using law to promote stigma (for example, related to smoking) even when such laws have undeniable benefits to the public's health by preventing morbidity and mortality (Bayer, 2008).

### **C. Stigma, Prejudice, and Discrimination of LGB<sup>2</sup> People have been Widespread in World Societies.**

For many decades LGB people have been stigmatized. Homosexuality has been portrayed, wrongly and stereotypically, as degenerate, criminal, and a mental and physical illness. This has led to wide spread discrimination against LGB people.<sup>3</sup>

Stigma and stereotypes inflame rhetoric against LGB people by using themes that erroneously associate homosexuality with child molestation; accusing LGB people of so-called “recruiting” children (suggesting that LGB people incite children to become LGB); portraying LGB people as hypersexual; associating homosexuality with disease, including HIV and AIDS; and generally portraying LGB people as unclean and unholy.

The accusation that homosexuality is associated with pedophilia has been a particularly venomous rhetoric used by anti-gay activists in the West and, more recently, in Africa and other countries (Angelides, 2009). The accusation appeared in the United States in anti-gay campaigns

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<sup>2</sup> In this report I refer to the LGBT community when relevant and specifically to LGB and transgender people, separately, as relevant. For example, when most of the issues concern sexual orientation, or when most research stems from studies of LGB people—as in this section—I refer to LGB persons. This does not indicate that some statements here are not also relevant to transgender people. Also, as I note below, especially in writings from Uganda, *transgender* can sometimes overlap with sexual identity.

<sup>3</sup> Many sources discuss a history of discrimination, stigma, and prejudice against lesbian/gay persons including, among others, D’Emilio & Freedman (1988), Katz (1976,1995), Weeks (1989). *See also* “Brief of the Organization Of American Historians and the American Studies Association as Amici Curiae In Support of Respondents” submitted to the Supreme Court of the United States, *Hollingsworth v. Perry* (12-144) February 2013.

such as Anita Bryant’s 1977 “Save Our Children” campaign that successfully repealed a Dade County, FL ordinance prohibiting anti-gay discrimination and, more recently, in a successful campaign by proponents of Proposition 8 in California in 2008 to bar same-sex couples from marriage. A review of the evidence, including a careful assessment of each purportedly scientific citation provided by advocates of the view that homosexuality is associated with pedophilia, led Herek (n.d) to conclude, “The empirical research does not show that gay or bisexual men are any more likely than heterosexual men to molest children. This is not to argue that homosexual and bisexual men never molest children. But there is no scientific basis for asserting that they are more likely than heterosexual men to do so.”

Another central aspect of stigma about LGB people concerns family relations and intimacy (Meyer & Dean, 1998). LGB people have long been portrayed as incapable of—and even uninterested in—sustained intimate relationships. This maliciously and erroneously places LGB people and their sexual orientation outside the so-called normal universal human experience of intimacy and love.

#### **IV. Stigma and Prejudice Expose LGB People to Minority Stress**

##### **A. Minority Stress Uniquely Impacts LGB People**

Stress, such as a life event, is “any condition having the potential to arouse the adaptive machinery of the individual” (Pearlin, Horwitz, & Scheid, 1999, in Meyer 2003, p. 675). Using engineering analysis, stress can be described as the load relative to supportive surface (Wheaton, Horwitz, & Scheid, 1999, in Meyer 2003, p. 675). Like a surface that may break when load weight exceeds its capacity to withstand the load, so has psychological stress been described as having a potential to get to a breaking point beyond which an organism may reach “exhaustion”



and even death (Selye, 1993). In over 40 years of research, researchers have shown that stress causes mental and physical disorders (Thoits, 2010).

Stressors include major life events (e.g., loss of a loved one), chronic conditions (e.g., unemployment), and minor events and instances (e.g., rush hour traffic in a big city). Such stressors are ubiquitous—all individuals in modern societies are exposed to them. In my research, I have referred to these as *general* stressors (Meyer, Schwartz, & Frost, 2008). But added sources to such general stressors that affect all people are stigma, prejudice, and discrimination. People in disadvantaged social statuses are exposed to stressors related to their stigmatization in society. I have referred to this as *minority* (also *social*) stress (Meyer, 1995; Meyer, 2003; Meyer & Frost, 2013). Minority stress stems from social disadvantage related to structural stigma, prejudice, and discrimination. “*Minority stressors . . . strain individuals who are in a disadvantaged social position because they require adaptation to an inhospitable social environment*” (Frost & Meyer, 2009, p. 98).

By definition, minority stress is unique in that it relates to stigma and prejudice toward LGB people but not heterosexuals and thus requires special adaptation uniquely by LGB people. Therefore, minority stress confers on LGB people a unique risk for diseases that are caused by stress. Exposure to minority stress is chronic in that it is attached to persistent social structures, but it can impact LGB people as both acute (e.g., a life event, such as victimization by antigay violence or firing from a job due to one’s gay identity) and chronic stress (e.g., heightened vigilance required to prevent victimization by antigay violence).

Against such stress, LGB people, individually and as a community, mount coping efforts and build resources that may buffer the toll of stress. Personal coping includes, for example, a sense of mastery and family support. Community-level coping refers to the mobilization of

supportive services, including, for example, a sense of connectedness and affiliation with the gay community (Meyer, 2003; Kertzner, Meyer, Frost, & Striratt, 2009). The impact of stress on the etiology of illness results from the force of both stress and coping.

In my research I have described four pathways through which social stigma is manifested in the lives of people who are members of stigmatized groups. I referred to these as *minority stress processes* and described them as: (a) chronic and acute prejudice events and conditions, (b) expectation of such events and conditions and the vigilance required by such expectation, (c) concealing or hiding of one's lesbian or gay identity, and (d) internalization of social stigma (internalized homophobia).

## **B. Minority Stress in Transgender Individuals**

Research has also shown how minority stressors impact the health of transgender and gender non-conforming individuals (Testa, Habarth, Peta, Balsam, & Bockting, 2015; Hendricks & Testa, 2012; Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013). These writings suggest that similar minority stressors are applicable to gender minorities as has been described for sexual minorities. A unique source of stress concerns gender non-affirmation of transgender or gender non-conforming individuals in formal and informal social interactions (Sevelius, 2013; Testa, Habarth, Peta, Balsam, & Bockting, 2015). Gender affirmation refers to the experience that society and individuals in both formal and informal interactions respect and affirm one's gender identity regardless of perceived transgressions of gender roles and expectations. For example, a person who was assigned male at birth but identifies and presents as female may find hostility because of social expectations that she adhere to her male sex as assigned at birth. Such a person may experience stress from both informal sources—family, friends, and strangers in daily interactions—and in formal transactions—such as not having an

identity card or other identifying documents that display her gender as she identifies it and as she presents in hair and clothes, mannerism, etc.

### **C. Prejudice Events**

Among the minority stressors is what I have referred to as prejudice events—events stemming from homophobic prejudice, discrimination, and violence. Prejudice events include the *structural* exclusion of lesbian and gay individuals from resources and advantages available to heterosexuals.

Prejudice events also include *interpersonal* events, perpetrated by individuals either in violation of the law (e.g., perpetration of hate crimes) or within the law (e.g., lawful but discriminatory employment practices). There are numerous accounts of the excess exposure of LGB people to such prejudice events (Herek, 2009a, 2009b; Meyer 2003; Meyer, Schwartz, & Frost, 2008). My studies have also shown that unlike other minority groups, anti-gay events can occur at home and be perpetrated by family members, such as in the case of the 43-year-old Latino man who at age 13 was raped and brutally beaten to unconsciousness by a family member who, in the respondent’s words, “raped me because I was gay and to teach me what a faggot goes through” (Gordon & Meyer, 2007, p. 62), or in the case of youth who were kicked out of their homes and became homeless because of their family’s rejection of their homosexuality (Durso & Gates, 2012).

Hate crimes are a particularly painful type of prejudice event because they inflict not only the pain of the assault itself, but also the pain associated with the social disapproval of the victim’s stigmatized social group. The added pain is associated with a symbolic message to the victim that they and their kind are devalued, debased, and dehumanized in society. Such victimization affects the victim’s mental and physical health because it damages his or her sense

of justice and order (Frost, Lehavot, & Meyer, 2013; Herek, Gillis, & Cogan, 1999). That is, the impact is the result not only the pain of the assault but the pain reverberated through the act of the entire community's disapproval, derision, and disdain. Prejudice events may be perpetrated by one person, but it is the implied message of hate from a larger community that makes hate crimes especially painful.

The added symbolic value that makes a prejudice event more damaging than a similar event not motivated by prejudice exemplifies an important quality of minority stress: prejudice events can have a powerful impact “more because of the deep cultural meaning they activate than because of the ramifications of the events themselves . . . a seemingly minor event, such as a slur directed at a gay man, may evoke deep feelings of rejection and fears of violence [seemingly] disproportionate to the event that precipitated them” (Meyer, 1995, p. 41-42). Therefore, stress related to stigma and prejudice is not assessed solely by its intrinsic characteristics, such as its magnitude, but also by its symbolic meaning within the social context. Thus, even a minor event or instance can have symbolic meaning and thus create pain and indignity beyond its seemingly low magnitude.

Even seemingly minor “everyday discrimination” occurrences can have a great impact because of the symbolic message of social disapproval. In interviewing lesbian and gay respondents for my study, my researchers and I heard numerous reports of verbal assault and harassment (Gordon & Meyer, 2007). Such instances do not qualify as *major* life events because they are seemingly minor by any objective measure (in stress terms, these incidents bring about little objective change and, therefore, require little adaptation compared to major events such as needing to find a new job after losing one's job). Nonetheless, these and similar *everyday*

*discrimination* instances can be damaging even if they are not major events because of the symbolic message of rejection that they convey.

Indeed, even stressful *non-events* can be damaging (Meyer, Ouellette, Haile, & McFarlane, 2011). Stressful non-events are expected events or experiences that do not happen when expected. Examples of non-events include expected life course milestones that were frustrated, like a job promotion not received when expected. Family relation milestones, such as getting married, having children, and having grandchildren are among the most widely expected events and not achieving these can be a significant stressor (Neugarten, Moore, & Lowe, 1965). Lesbian and gay persons share these expectations for life course milestones, as do their families, friends, colleagues, and acquaintances. Family relations—including using labels such as “husband,” “wife,” “mother,” and “grandfather”—carry important roles through which people are identified and through which they identify themselves. Failing to achieve such milestones is personally stressful and socially stigmatizing. Of course, the stronger the social expectations (such as that one should marry a person of the opposite sex by a certain age) are in a society, the greater the experience of stress to individuals who cannot achieve these expectations.

#### **D. Expectations of Rejection and Discrimination**

Expectations of rejection and discrimination are stressful because of the almost-constant vigilance required by members of minority groups to defend and protect themselves against potential rejection, discrimination, and violence (Meyer, 2003). Unlike the concept of prejudice events, where a concrete event or situation—a major or minor life event or a chronic stressor—was present, expectations of rejection and discrimination are stressful even in the absence of a prejudice event. “Because of the chronic exposure to a stigmatizing social environment, ‘the consequences of stigma do not require that a stigmatizer in the situation holds negative

stereotypes or discriminates” (Crocker, 1999, in Meyer, 2003, p. 681). The vigilance required in such a state is similar to the classic example of stress experienced in the *flight or fight* stressor that brings about a biophysiological stress response—the primary stress process identified by Cannon in the early 20<sup>th</sup> century (Cannon, 1932).

### **E. Concealing Stigmatizing Identity**

Concealing their sexual minority identities is a way in which some LGB people must cope in hope of protecting themselves from the stigma and prejudice and consequent rejection and violence. Concealing a lesbian or gay identity offers some protections. For example, a person who successfully conceals his or her lesbian or gay identity is less likely to be a victim of anti-gay violence than if he or she did not do so (Rosario, Hunter, Maguen, Gwadz, & Smith, 2001). But, paradoxically, concealing one’s lesbian or gay identity is itself a significant stressor for at least three reasons.

First, people must devote significant psychological resources to successfully conceal their lesbian and gay identities. Concealing requires constant monitoring of one’s interactions and of what one reveals to others. Keeping track of what one has said and to whom is very demanding and stressful, and it leads to psychological distress. Among the effects of concealing are preoccupation, increased vigilance of stigma discovery, and suspiciousness (Pachankis, 2007). For example, researchers studying the cognitive efforts required to conceal stigmatizing conditions described the person who attempts to conceal his or her stigma as living in a “private hell” (Smart & Wegner, 2000, in Meyer, 2003, p. 681). The concealing effort, and the required cognitive efforts can lead to significant distress, shame, anxiety, depression, and low self-esteem (Frale, Platt, & Hoey, 1998).

Second, concealing has harmful health effects by denying the person who conceals his or her lesbian or gay identity the psychological and health benefits that come from free and honest expression of emotions and sharing important aspects of one's life with others. Health psychology research has shown that expressing and sharing emotions and experiences can have a significant therapeutic effect by reducing anxiety and enhancing coping abilities (Meyer, 2003; Pachankis, 2007). In contrast, repression and inhibition can induce health problems. For example, Cole and colleagues found that HIV-related diseases advanced more rapidly in a group of gay men who concealed their sexual identity than in a group of gay men with similar HIV infections who did not conceal their sexual identity (Cole, Kemeny, Taylor, Visscher, & Fahey, 1996). In another study, the authors showed a similar pattern among HIV-negative men regarding health outcomes unrelated to HIV (Cole, Kemeny, Taylor, & Visscher, 1996).

Third, concealment prevents lesbian and gay individuals from connecting with and benefiting from social support networks and specialized services for them. Protective coping processes can counter the stressful experience of stigma (Meyer, 2003). Coping processes include the group's effort to counter negative societal structures by creating alternative norms and values and providing role models and social support. Access to and use of such community resources is beneficial to stigmatized minority group members whose experiences and concerns are not typically affirmed in the larger community. For example, lesbian and gay communities—whether open and more formal as available in some societies, or informal and even clandestine—provide role models of successful same-sex relationships, provide alternative values that support lesbian and gay families, and, in general, counter homophobic messages and values (Weston, 1991). LGB people who conceal their sexual identity in an effort to protect themselves, avoid such affiliations in an effort to protect themselves from homophobia but, paradoxically, are

deprived of significant resources that potentially ameliorate the negative health impact of minority stress.

## **F. Internalized Homophobia**

Internalized homophobia (also described as *internalized stigma*, and *self-stigma*) refers to the internalization of negative societal attitudes among LGB people. Internalized homophobia is an insidious stressor because it is unleashed by the LGB person toward himself or herself due to socialization in a society that stigmatizes homosexuality (Meyer, 2003; Herek, 2009a).

Heterosexual, lesbian, gay, and bisexual individuals internalize the prejudice and stigma of homosexuality, but the effects of this internalization is quite severe for the LGB person as he or she internalizes stereotypes suggesting that being an LGB person is sinful, unnatural, and incompatible with intimacy and family life.

Psychologists have described a developmental process through which a gay person comes to recognize and acknowledge his or her sexual orientation, and sometimes, but not necessarily, acquires a gay identity (Eliason & Schope, 2007). This process, referred to as “coming out,” can be brief and unproblematic to the person, especially if supportive networks are available to him or her, or it can be difficult and fraught with confusion, doubt, and guilt. In the *coming out process*, the LGB person must unlearn such false stereotypes and prejudicial attitudes and adopt new, healthier attitudes and self-perceptions.

Lesbians, gay men, and heterosexuals, as members of society, internalize and, in turn, propagate stigma and stereotypes about LGB people. LGB people, who as children and youth are typically raised by heterosexual families in heterosexual communities, rely on such false stigmatized depictions to learn about the lives of LGB people. Thus, they are at risk of believing that these stigmatized depictions are correct and apply to themselves and may lead to self-



rejection and hate. Heterosexual people, including parents, friends, and children of LGB people, are similarly affected by false stigmatized notions of lesbians' and gay men's lives and often reinforce such stereotypes as they propagate them. For example, in a study of LGB people in California's Bay Area, one gay man was quoted saying, "My image of gay life was very lonely, very weird, no family." A lesbian in the same study remembered that, after coming out as lesbian to her mother, she was told, "You'll be a lesbian and you'll be alone the rest of your life. Even a dog shouldn't be alone" (Weston, 1991, p. 25).

An important aspect of one's self that is affected by internalized homophobia is the *possible self* (Markus & Nurius, 1986)—the view of the self not only as it is but as that which it can become in the future. Possible selves are an important aspect of one's aspiration and motivation. Possible selves determine not only future success but also current hope and well-being. But possible selves are formed from one's perception of current social norms, values, and expectations for the future. Among the important sources of possible selves are social conventions, social institutions, role models, and expectations and aspirations of others.

Upon realizing and accepting that one is or may be LGB, an LGB person must chart a new possible life course that is different from the possible life course of heterosexuals. Indeed, gay youth "recognize that they will not have the same course of life as their parents and heterosexual peers. They will not have a heterosexual marriage; they may not have children or grandchildren. . . . In a society such as ours, where much store is placed in competing and keeping up with one's friends and neighbors, such an identity crisis can unhinge not only sexuality but belief in all future life success" (Herdt & Boxer, 1996, p. 205).

Internalizing stigma has negative consequences for the health and well-being of LGB people. Because internalized homophobia disturbs the gay person's ability to overcome

stigmatized notions of the self and to envision a future life course, it is associated with mental health problems and impedes success in achieving intimate relationships (Meyer, 1995; Meyer & Dean, 1998; Frost & Meyer, 2009).

Empirical evidence has demonstrated that LGB people who have higher levels of internalized homophobia are less likely than LGB people with lower levels of or no internalized homophobia to sustain intimate relationships. Even if in a relationship, LGB people who have higher levels of internalized homophobia have a poorer quality of relationships (e.g., Meyer, 1995; Meyer & Dean, 1998; Frost & Meyer, 2009; Balsam & Szymanski, 2005; Otis, Rotosky, Riggle, & Hamrin, 2006).

### **G. Coping and Social Support**

Against these minority stress processes, LGB people engage in various coping and social support efforts. Coping refers to the kind of efforts an individual may engage in to alleviate the experience and impact of stress. Psychologists have described many types of coping that can be generally divided into problem- and emotion-focused coping. Problem-focused coping involves doing something, including seeking more information, to change the stressor or problem. For example, a person who was fired or laid off from a job may seek information about available resources to help her or him and actually attempt to garner such resources (e.g., get new skills training). Emotion-focused coping involves addressing the emotional impact of the stressor. For example, a person whose spouse has died may engage in various activities (e.g., create a memorial book) that makes her or him feel closer to the deceased spouse, get help from a therapist or doctor, etc.

Social support is another form of coping; it can be seen as coping done with the help of others. Social support is defined as the presence of emotional, practical, financial, and social

guidance from a network of friends, family, co-workers, and others. For example, it can involve support that is problem-focused, emotion-focused, and informational. Support can come from formal organizations or a group of friends and can, thus, involve intimate relationships and friends, more distant acquaintances, or even strangers.

The role of social support in health has been shown in many studies that look at different aspects of support (or potential for support) such as the social network's size, the quality of support, the frequency of support, etc. One of the earliest studies showed that individuals with more social contacts live longer than their peers who do not have as many social contacts (Berkman & Syme, 1979 study of Alameda County, CA). An extensive body of research led Beals, Peplau, & Gable (2009) to conclude, "The association between greater perceived social support and better physical and mental health outcomes is one of the most robust findings in health psychology" (p. 868).

Stress research shows that people's health outcomes differ based on levels of coping, resilience, and social support that they can mount in response to stress. For example, a person who has lost a job can have better outcomes if he or she is provided support than a similar person who is not provided support.

Research suggests that support from LGB friends that directly addresses stress related to sexual identity (minority stress) is more effective—for example, in relieving emotional distress—than support from family members and heterosexual friends (Doty, Willoughby, Lindahl, & Malik, 2010). This is consistent with theory that emphasizes the importance of similar others within one's social network as a source of solidarity in confronting stigma and improving mood and self-esteem (Doty, Willoughby, Lindahl, & Malik, 2010; Frable, Platt, & Hoey, 1998).

Social support provides opportunities to receive informational, instrumental, and emotional support when coping with both general and minority stressors. Affiliation with other LGBT persons can provide a source of information relevant to the LGBT person's life. Such information tends to not be highlighted by mainstream institutions and organizations, which, typically, cater to the needs of the larger general population. LGBT-specific support can provide information and education about means to achieve important life goals. Such information can include informal stories about others in the community who manage to live a happy life as LGBT persons, about how to achieve intimate relationships, and about areas where LGBT people may find more welcoming opportunities for employment and economic development. Information is also necessary for specialized health needs of LGBT people. Relevant health information can also include information about healthcare providers who provide unbiased health services and are welcoming to LGBT people. Information may also be provided about preventive resources that cater to the LGBT community, such as the Trevor Project, a U.S. national helpline that provides support to LGBT people at risk for suicide. Affiliation can also provide opportunities to learn about and participate in political activities that support the rights of LGBT people, information about political parties and candidates, and information about proposed legislation and special ballots or initiatives of interest to LGBT people. LGBT people who are isolated from others in their communities may be deprived of access to such information and resources, or may have greater difficulty to find information compared with LGBT people who have access to supportive services.

Community resources and social support can ameliorate the negative impact of the stressors outlined above. In addition, LGBT people who need supportive services, such as competent mental health services, may receive better care from sources that are LGBT-

affirmative (e.g., a specialized gay clinic; Potter, Goldhammer, & Makadon, 2008). But individuals who conceal their lesbian and gay identities are likely to fear that their sexual identity would be exposed if they approached such resources. More generally, concealing can lead to social isolation as the person who conceals his or her sexual identity may avoid contact with other lesbian and gay persons, while also feeling blocked from having meaningful honest social relations with heterosexual individuals.

## **V. Minority Stress Adversely Affects the Health and Well-being of the LGBT Population**

Minority stress causes serious injury in the form of psychological distress, mental health problems, suicide, and lowered psychological and social well-being. Studies have concluded that minority stress processes are related to an array of mental health problems, including depressive symptoms, substance use, and suicide ideation (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Cochran & Mays, 2007; Herek & Garnets, 2007; King et al., 2008; Meyer, 2003; Cochran & Mays, 2013).

Also, although less often studied, lesbian, gay, and bisexual individuals have lower levels of psychological and social well-being than heterosexual people because of exposure to minority stress, such as stigma and discrimination experiences (Frale, Wortman, & Joseph, 1997; Kertzner, Meyer, & Dolezal, 2003; Riggle, Rostosky, & Danner, 2009). This is not surprising because well-being, especially *social well-being*, reflects the person's relationship with his or her social environment: "the fit between the individuals and their social worlds" (Kertzner, Meyer, Frost, & Stirratt, 2009, p. 500). Other studies have shown, for example, that stigma leads lesbian, gay, and bisexual persons to experience alienation, lack of integration with the community, and problems with self-acceptance (Frale, Wortman, & Joseph, 1997).

Minority stress is also associated with a higher incidence of reported suicide attempts among non-heterosexuals as compared with heterosexual individuals (e.g., Cochran & Mays, 2000; Gilman et al., 2001; Herrell et al., 1999; Marshal et al., 2011; Meyer, Dietrich, & Schwartz, 2008; Safren & Heimberg, 1999). Higher rates of suicide attempts among members of sexual minorities are related to minority stress encountered by youth due to coming out conflicts with family and community (Ryan, Huebner, Diaz, & Sanchez, 2009). Youth is a time that can be particularly stressful, a time when young people realize they are lesbian, gay, or bisexual, and often disclose their sexual minority identities to parents, siblings, and others (Flowers & Buston, 2001).

Minority stressors stemming from social structural discrimination have serious negative consequences on mental health. For example, lesbian, gay, and bisexual men and women who live in U.S. states without laws that extend protections to sexual minorities (e.g., job discrimination, hate crimes, relationship recognition) demonstrate higher levels of mental health problems compared to those living in U.S. states with laws that provide equal protection (Hatzenbuehler, Keyes, & Hasin, 2009).

A number of studies have also demonstrated links between minority stress factors and physical health. For example, one study (Frost, Lehavot, & Meyer, 2013) found that lesbian, gay, and bisexual people who had experienced a prejudice-related stressful life event (e.g., assault provoked by known or assumed sexual orientation, being fired from a job because one's sexual minority identity) were about three times more likely than those who did not experience a prejudice-related life event to have suffered a serious physical health problem over a 1-year period. This effect remained statistically significant even after controlling for the experience of other stressful events that did not involve prejudice, as well as other factors known to affect

physical health, such as age, gender, socioeconomic status, employment, and lifetime health history. Thus, prejudice-related stressful life events were more damaging to the physical health of lesbian, gay, and bisexual people than general stressful life events that did not involve prejudice (Frost, Lehavot, & Meyer, 2013).

Studies also found that concealment of gay identity among HIV positive gay men was associated with lower CD4 counts, which measure the progression of HIV disease (Strachan, Bennett, Russo, & Roy-Byrne, 2007; Ullrich, Lutgendorf, & Stapleton, 2003). Another study of HIV-negative gay men showed that those who concealed their gay identity experienced a higher incidence of disease—including infectious diseases and cancer—than men who did not conceal their gay identity (Cole, Kemeny, Taylor, & Visscher, 1996). Other studies found that exposure to discrimination was related to outcomes such as number of sick days and number of physician visits (Huebner & Davis, 2007).

## **VI. Uganda's LGBT Population**

### **A. Homosexuality in Uganda**

Despite recent claims by some African, including Ugandan, leaders, religious figures, members of the press, and other citizens that homosexuality is foreign to Africa and is a Western import or influence, research on African sexualities has described multiple forms of homosexuality and transgender experiences throughout the studied history (the study of African sexuality begun primarily at the beginning of the 20<sup>th</sup> century) (Murray & Roscoe, 1998). Like many in present day Africa, anthropologists studying African sexualities too often denied the existence of homosexuality even as they described it. For example, in 1938 Herskovits described homosexuality as “situational and opportunistic” when describing that “a boy may take the other

‘as a woman’ this being called *gaglgo*,” even as he asserted that “sometimes an affair of this sort persist during the entire life of the pair” (Murray & Roscoe, 1998, p. xiii).

Addressing the question whether homosexuality was foreign to Africa, a review of the Academy of Sciences of South Africa in collaboration with the Uganda National Academy of Sciences concluded that “there is . . . no basis for the view that homosexuality is ‘un-African’ either in the sense of being a ‘colonial import’, or on the basis that prevalence of people with same-sex or bisexual orientations is any different in African countries, compared to countries on any other continent” (Academy of Science of South Africa, 2015, p. 37).

Still, indigenous traditions of homosexuality and transgender experiences are important for understanding public and political attitudes in Uganda and elsewhere in Africa. One feature of these traditions seems to be a greater overlap between homosexual (LGB) and transgender identities when compared with the way they are treated in current American culture. For example, taking on women’s social roles and appearances (such as garb), which are features of gender identity as I described above, are often a feature of male homosexuality in traditional African societies (academic studies of female homosexualities in the history of Africa are scarce but show similar features). Also, in African, like some other societies, social and sexual roles, such as so-called male “passive” versus “active” roles in same-sex sexual activities, often take precedent over Western-style sexual orientation identities, which do not typically consider sexual practices in delineating identities (Amory, 1998).

In this context, it should be noted that even if particular LGBT identities were a new phenomenon, that could not be a justification to stigmatize, demonize, and marginalize people in Africa who adopt a modern nomenclature. Today, globalization allows for cultural and social



influences and cross-fertilization on the articulation of identities that were not possible in earlier periods (Altman, 2001; Sutton, 2007).

Because even today there seems to be overlap between sexual orientation and gender identity and expression, in this report I do not make distinctions in general statements about LGBT people and only distinguish LGB people and transgender people when the evidence I refer to clearly and differentially pertains to LGB versus transgender individuals.

### **B. How many LGBT people are in Uganda?**

To date, there is no good estimate of the prevalence of homosexuality in Africa in general, or in Uganda specifically (van Griensven, 2007; Cáceres, Konda, Pecheny, Chatterjee & Lyerla, 2006). Several studies that focus on assessing HIV/AIDS in Uganda have documented both the presence of gay/bisexual men and the high prevalence of same-sex sexual activity. For example, a study of sexual risk behaviors among young commercial motorcycle taxi drivers in Uganda's capital, Kampala, found that many men had both casual and regular partners (68%) and commercial sex (33%). Arriving at population estimates using Respondent-Driven Sampling method, the authors found that almost 9% of the men had sex with other men (Lindan et al., 2014). In both this and other studies of gay and bisexual men (Kajubi et al., 2008; Hladik et al., 2012; Raymond et al., 2009), the overwhelming majority (more than 90%) of the gay and bisexual men were Ugandan nationals, refuting the suggestion that it is foreigners (i.e., non-Ugandan nationals) who are LGB in Uganda.

The Crane group, a collaborative between Makerere University School of Public Health, U.S. Centers for Disease Control and Prevention, and the Ugandan Ministry of Health, conducted several studies in Kampala related to the HIV/AIDS epidemic. In one study of youth, using a sampling approach designed to represent the population of secondary school students

aged 15 and older in Kampala, researchers assessed sexual orientation by inquiring about attraction. (Because youth may not have much sexual experience, this is a preferred method of assessing sexual orientation in youth). The researchers found that among male students about 3% stated being attracted only to males, 6% said they were attracted mostly to males, and 13% said they were equally attracted to males and females—that is, a total of 22% had same-sex attraction. Of the female students, 6% said they were attracted to females only, 6% mostly to females, and 19% said they were equally attracted to males and females—that is, a total of 31% had same-sex attraction. Of the youth who had had sex, 1.5% of the males and 8% of females had some same-sex sexual experience.

These numbers are certainly not lower than U.S. studies that find about 7% of youth to be non-heterosexual (Kann et al., 2011), again demonstrating that homosexuality is not more uncommon in Uganda than in the U.S. Although these studies are insufficient to assess the size of the Ugandan LGBT population, they clearly show that same-sex behavior is present in both youth and adults.

Using a very conservative estimate of 3% lesbian and bisexual women and the same for gay and bisexual men in Uganda—U.S. estimates are 3.6% and 3.4%, respectively, based on sexual identity measures only—and then applying this only at the Ugandan population of men and women over age 18 (Uganda Bureau of Statistics, 2014), I have calculated the number of LGB in Uganda to be about 450,000 men and women.

Of course, this assumes that the comparison to U.S. estimates is reasonable, but the evidence from African studies and the consensus among researchers who attempted this estimate is that this is reasonable (e.g., Bariyo, 2014; van Griensven, 2007). It is important to remember that this estimate is very conservative as it does not include youth under age 18. Also, Epprecht

described that because of cultural pressures to marry and have children, there is an African culture of “secretive *de facto* bisexuality,” which he described as “enjoying same-sex relations while still fulfilling social obligations of heterosexual marriage and the appearance of virility/fertility” (Epprecht, 2012, p. 226). My estimate does not include the many more people who have same-sex behavior at some time over their lifetime and are not identified as LGB but nevertheless cannot be classified as completely heterosexual.

### **C. Uganda’s Anti-Homosexuality Law**

Criminalization of same-sex acts became incorporated into Ugandan law with the application of British law when Uganda became a British Protectorate in 1894. An “Order-in-Council provided that jurisdiction should so far as circumstances permitted be exercised upon the principles of and in conformity with the substance of the law for the time being in force in England. This introduced British law and Victorian morality in Uganda” (CSCHRCL, 2013, p. 28). The situation in Uganda is similar to other African nations, where laws against same-sex behavior were incorporated into post-colonial law from colonial law. As Kaoma (2013, p. 77) noted, “Postcolonial Africa is highly critical of colonial laws and values, but one colonial legacy is the English law that reads the same across Anglophone Africa. ‘Carnal knowledge against the order of nature’ is illegal in many African countries today, just as it was in colonial times. Compounded by the religious teachings of Christianity and Islam, this law has been assimilated into all aspects of African society and is defended with pride.”

Uganda’s Anti-Homosexuality Bill (AHB), first introduced in 2009 and later enacted as the *Anti-Homosexuality Act (AHA, 2014)*, originally proposed the death penalty for a second conviction of consensual sex between adults of the same gender, and in other cases with aggravating factors, imprisonment for failure to report on others suspected of being homosexual,

and for “promotion of homosexuality” (AHB, 2009). Later the bill was revised to remove the death penalty by substituting it with life in prison. The reporting requirement was also removed but “aiding and abetting” homosexuality remained. The bill was signed into law by President Museveni on February 24, 2014 and later annulled by the Uganda Constitutional Court on August 1, 2014 when the Court found that the bill was passed without the requisite quorum (*Oloka-Onyango & 9 Ors v Attorney General*).

***Uganda’s Anti-Homosexual Bill propagated stigma against LGBT people***

The Anti-Homosexuality Bill was introduced and widely discussed in Uganda since 2009. The Bill’s impact goes far beyond what one would expect in implementation of the now-annulled law. Because of the wide public awareness of the Bill, and, indeed, the public and religious incitement against LGBT people in Uganda that it has elicited, the AHB is an example of how laws (in this case, even if annulled) enhance and enshrine stigma against LGBT people.

It is important to note that since the 19<sup>th</sup> century, Uganda law has criminalized sexual behavior between people of the same sex even without the Anti-Homosexuality Act. Even if one believes that homosexual acts ought to be criminalized, which goes counter to basic guarantees of human rights (United Nations, 2015), the purpose of the Anti-Homosexuality Act was suspect. Thus, the Anti-Homosexuality Act reveals an attempt to further stigmatize LGBT people as people, not only for their alleged objectionable sexual behavior.

Indeed, the Anti-Homosexual Bill was unique in that it cast a wide net and sought not only to criminalize same-sex sexual conduct but *identity* in the sense that it criminalizes many facets of life, the including officiating same-sex marriages, “promoting” homosexuality, failing to report or “aiding and abetting” others suspected of being in violation of the law, which was not limited to sexual conduct (AHB, 2009). The preamble to the original legislation was replete

with justifications such as the “need to protect children and youths of Uganda” and “emerging internal and external threats to the traditional heterosexual family” (AHB, 2009; see also Proceedings of the Parliament of Uganda, 4/1, 4/15, 4/29, 2009 and 12/20,13). This unique feature of the law—that it targets the person not the acts—is especially indicative of the relationship of the law and stigma. Sociologist Irwin Goffman (1963), in the classic text on stigma, referred to the stigmatized individuals as having a “spoiled identity” due to the social designation of stigma to them. In the Anti-Homosexual Bill, stigma and criminality are attached not to specific acts but to the person as a whole. Thus, the bill, later modified and enacted as the AHA, appears to purposefully stigmatize and dehumanize LGBT persons.

Analysis by the Civil Society Coalition on Human Rights and Constitutional Law (CSCHRCL, 2013) of Makerere University in Kampala is consistent with this view, suggesting that “further criminalisation of homosexuality would simply drive more LGBTI persons underground, increase discrimination based on sexual orientation and gender identity, and further condone violations of the constitutional rights of LGBTI persons by third parties” (CSCHRCL p. 21).

The following description by CSCHRCL (p. 22) about the debates that ensued after the introduction of the Anti-Homosexuality Bill demonstrates the significant role that laws can play in enhancing stigma and advancing prejudice, discrimination, and violence against a persecuted minority:

The Bill attracted a lot of debate and attention among the Ugandan populace and the international community respectively. At the height of this, the Rolling Stone tabloid published pictures and addresses of suspected gay people and called for their hanging. Consequently, many of those named faced various threats and some were forced to leave the country. . . . [Later], media coverage of the burial ceremony of David Kato, [a gay rights

activist who was killed at his home], outed many of the members of the LGBTI community and put them at further risk.

## **VII. Uganda's Anti Homosexual Act Exposed LGBT People to Minority Stress**

### **A. Increased Exposure to Minority Stressors**

Above, I described internalized homophobia, expectations of rejection, hiding (concealing) one's sexual identity, and various stress events and conditions as processes that define minority stress. All of these are evident in reports from Uganda.

Although internalized homophobia is less often studied, one study suggested that the general social rejection and, specifically the Anti-Homosexuality Bill, may lead to higher experiences of internalized homophobia that have an adverse effects on safe sex practices (Ross, Kajubi, Mandel, McFarland, & Raymond, 2013).

Uganda's social environment, with its overt and explicit homophobia and hostility and violence toward LGBT people, would cause LGBT people to expect harm, which induces chronic stress as defined by minority stress. This onslaught of institutional assault and condemnation "has created an environment where LBT/kuchu people are beaten in public social places, chased out of restaurants and bars, and many lost their jobs and others lost their families" (FARUG/ IGLHRC, 2010, p. 16). That State and governmental agencies, including the police, are complicit in effecting anti-LGBT acts would reasonably make LGBT people feel unprotected by the State and require them to maintain high levels of vigilance to secure the safety of themselves, their intimate partners, and their children.

In terms of exposure to an array of stressful events and conditions, evidence suggests that the introduction of the Anti-Homosexual Bill in 2009 inflamed an already homophobic social environment, leading to aggressive and violent persecution of LGB people (FARUG/ IGLHRC, 2010). Because homophobia is seen as sponsored by the authorities of the Church and State, acts

of rejection and violence were perpetrated with impunity and often with the blessing of the law and religious leaders. A report by Freedom and Roam Uganda (FARUG) and the International Gay and Lesbian Human Rights Commission (IGLHRC) recorded government officials supporting the Anti-Homosexuality Bill and inciting action against LGB people. For example, Minister of Ethics, James Nsaba Buturo reportedly said: "...Ugandans should strengthen their mobilisation against the gay movement because the government is also committed to support them ... We hear that some students in our schools have been lured into homosexuality. I appeal to the investigative arms of the government to quickly compile reports of such students and their schools so that touch action is taken against them" (FARUG/IGLHRC, 2010, p. 15).

Media has actively participated in the persecution of LGBT people by publishing articles that incite violence and include photos, work place, and home addresses of alleged LGBT people. For example, a 2006 *Red Paper* article wrote: "To rid our motherland of the deadly vice [of lesbianism], we are committed to exposing all the lesbos in the city (...) Send more names [with] the name and occupation of the lesbin [sic] in your neighborhood and we shall shame her" (FARUG/IGLHRC, 2010, p. 15). "...on October 2, 2010, the tabloid *Rolling Stone* printed a story with the title, "100 Pictures of Uganda's Top Homos Leak." The cover of the paper calls to, "Hang Them" and includes photos of a number of Ugandan LGBT activists and human rights defenders" (FARUG/IGLHRC, 2010, p. 16).

Multiple sources describe severe stressful events and conditions that constitute minority stress. The FARUG/IGLHRC report describes numerous incidents of rejection, discrimination, harassment, and violence as recounted by victims in Uganda. This, and other reports by LGBT people in Uganda that I was able to locate, echo in more severe, public, and violent forms, the type of prejudice events I have researched and written about in the context of the United States.

(An example of accounts by LGBT people writing about their experience in Uganda is the self-published *Bombastic* magazine).

Incidents included in witness accounts recounted in the FARUG/ IGLHRC report include harassment and violent attacks including rape in both public places and home; harassment at work and termination of employment for the stated reason that someone is suspected of being LGBT; and harassment and discrimination at schools, clinical facilities, and housing.

There are many accounts of police and other governmental institutions participating in the rejection, discrimination, and harassment of LGB people. For example, a lesbian was denied a passport renewal when the government clerk told her that she “was not Ugandan and that am just impersonating” (FARUG/ IGLHRC, 2010, p. 18). Indeed, there are reports that police officers openly and with impunity harass LGBT people and expect bribes. In many cases, there are no formal arrest records. As described by one witness: “If you’re arrested, there’s no report that you’re arrested. They put you in, to intimidate you and maybe extort money out of you. They know they’ve done something wrong by taking money from you, so there’s no report” (FARUG/ IGLHRC, 2010, p. 12-13).

Some reports (e.g., Joint report from the Danish Immigration Service’s and the Danish Refugee Council, 2014) suggest that there has been a concentrated effort by the Inspector General of Police (IGP) of the Uganda Police Force to curb police harassment (for example, by way of arrest and demand for bribe) and even to protect LGBT people in Uganda when they are threatened (for example, by mob attack). It is notable, however, that the reach of the IGP may be limited as various sources reported many incidents of harassment, such as arrests, that continue seemingly despite the IGP’s effort. Also, the same Danish government report describes a country and police force afflicted by bribery that is difficult to control, with Uganda ranking



among the most corrupt countries in the world. All this suggests that even honest efforts by the IGP to protect LGBT people may be hindered in an environment characterized by homophobia and corruption.

An independent source of confirmation for the picture painted by the reports in newspapers and by non-governmental, governmental, and international bodies (some cited above), comes from research, primarily in the context of HIV/AIDS and published in peer-reviewed journals, with gay/bisexual men and men who have sex with men (or *MSM*, referring to men engaged in same-sex sexual activity regardless of whether they also identify as gay or bisexual. By design, such research focuses on men only as they are perceived to be at greater risk for HIV/AIDS than lesbian and bisexual women. For example, a study of MSM (the majority of whom identified as gay or bisexual) reported that 39% of MSM have suffered homophobic abuse, including what the authors referred to as moral (including isolation, exclusion, 18%) verbal (threats, insults, 33%), physical (15.5%) and sexual violence (22.0%). The authors further noted that “abuse most frequently originated from family members (25.4%), sex partners (24.2%), and friends and acquaintances (24.1%)” (Hladik et al., 2012, p. 7). Another study of gay/bisexual men in Kampala similarly found that 27% of the men reported “being subject to some form of violence or abuse as a result of being gay or bisexual: of these, 32.8% indicated it was physical, 83.6% verbal, 42.6% moral (discrimination or humiliation based on being gay or bisexual) and 31.2% sexual: 62.3% indicated that they had been subjected to two or more forms of violence” (Ross, Kajubi, Mandel, McFarland, & Raymond, 2013, p. 412).

With nowhere to turn for protection, an atmosphere of persecution has created a stressful state of fear among LGBT people. In addition, LGBT people have to use their own resources, if

they have any, to afford any sense of security, as this witnesses described: “With the community now you have to keep shifting from this place and the other place because of the discrimination and the homophobia. ... Then you know, you become... you can't move freely. I can't even use public means of transport because I fear ... I'm living a forced life, an expensive life, I'm not supposed to go to public places, open places for shopping.” And another witness stated: “We have most of our LGBTI people who are... known, cannot just walk on the street. You have to look for a really secure place. And for you to find a very secure place where you can live where maybe it's fewer people, maybe like in a space like inside here, where you feel you're safe to go out and do whatever and come back in, it's very difficult. And it's very expensive. So you live like in fear, every day, like, what will happen to me?” (FARUG/ IGLHRC, 2010, p. 31).

From various other reports, I was able to identify numerous instances demonstrating the ill treatment of LGBT people in Uganda, including, among many others, those listed below:

1. In June 2012, police raided a human rights workshop attended by lesbian, gay, bisexual and transgender (LGBT) activists in Kampala (Amnesty International, 2012).
2. On January 27, 2014, police arrested a man on suspicion that he was gay and forcibly subjected the suspect to an anal exam and an HIV exam. Man was also paraded in the media, including in Red Pepper (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
3. On January 27, 2014, a transwoman was arrested and detained at Old Kampala Police Station. Because the police perceived her to be a man, she was detained with male inmates who insulted her verbally while in detention (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
4. On January 27, 2014, a woman was attacked by neighbors around her home. The neighbor had always insulted her that she was homosexual. They beat her up and threatened to rape her if she did not change her “behavior.” She later had to relocate (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
5. On January 28, 2014, the police at Ntinda arrested a Kenyan and a Belgian national on suspicion of practicing homosexuality (Consortium of Monitoring Violations Based on

Sex Determination, Gender Identity and Sexual Orientation, 2015).

6. In January 2014, two LGBTI defendants were arrested after one was thrown out of his house and beaten by local officials and neighbors on the basis of allegations that he was a homosexual. The pair was subjected to HIV examinations without their consent and an anal examination (Stewart, 76 Crimes, October 22, 2014).
7. In January 2014, when a man reported to the Police about an eviction, he was instead arrested on charges of having carnal knowledge against the order of nature and remanded to prison for three months (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
8. On February 9, 2014, a transman was detained at Kiira Road Police Station. The victim was detained in female detention cells. They alleged that he was a woman pretending to be a man with the aim of defrauding people. This exposed him to abuses and trauma (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
9. In February 2014, Red Pepper published a cover story on “200 top homos” in Uganda (McGrath, Global Post, February 25, 2014).
10. In February 2014 (reported), LGBTI activist was served with a 14-day eviction notice for his “gay work and sexuality” (Hogan, The Daily Beast, February 24, 2014).
11. On March 2, 2014, the police at Namirembe police post arrested a gay man and detained him after a tip off from someone that he was homosexual. He was later released without a charge (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
12. On March 6, 2014, a man was called by his friend to join him at his home. On arrival, he found two guards waiting; they dragged him to a friend’s home where he was detained for 11 hours. He was beaten and accused of wanting to recruit the friend into homosexuality (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
13. On March 17, 2014, the police arrested and investigated a man suspected of assaulting and stealing from a gay man and a transwoman. The two were locked in a house and beaten with sticks and wires by three men while they were being asked why they were homosexuals (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
14. On March 18, 2014, two men were detained on allegations of sodomy and released on police bond on April 17, 2014. The two men spent a total of 28 days in detention at the police station (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).

15. In March 2014, a Ugandan lesbian was served with an eviction notice. The landlord cited the anti-gay law as the reason (Brydum, Advocate, March 5, 2014).
16. In March 2014, a transgender person was rejected by his family and thrown out and his belongings set on fire. His relatives vowed to kill him rather than having a homosexual in the family (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
17. On April 3, 2014, Makerere University Walter Reed Project, an organization that was engaged in research on HIV, was raided by the police and a staff member arrested on allegations of promoting homosexuality in Uganda (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
18. On April 25, 2014, a gay man was arrested after he received a phone call to go to Kabalagala Police Station. On reaching there, he was taken to Katwe Police Station where he was told he had sodomized a person who had reported him to the police (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
19. On April 30, 2014, a man was arrested and detained at Kabalagala Police Station and produced in court after 12 days on May 12, 2014 (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
20. In April 2014, Uganda teenager committed suicide allegedly over the homophobic law (Morgan, Gay Star News, April 7, 2014). Gay rights activists have said they have heard of at least 17 LGBTI people who have attempted to kill themselves over the law. It is unknown how many succeeded in their attempt.
21. In April 2014 (reported), Ugandan teen was thrown out of his home, arrested, and tortured (Watson, Huffington Post, April 19, 2014). After his parents learned about his lovers, his parents demanded he leave their home immediately. He recalls, “they took me into the jail for two months and they tortured me to a severe extent. They asked me to reveal other groups of gays and give them names. But I didn’t tell, and they continued the torture every day. They tortured me every after my first day there and they took one to two days without giving me food. They beat me and beat me to every part on my body, in fingers, on the ankles, while asking me the other gay groups. The next month they took me to the court because they were expected my uncle to come and give out the proof that I was gay.” He was ultimately released and went to the streets.
22. In April 2014, a transman was refused treatment for malaria by health workers. He had sought treatment from a clinic nearby. A nurse questioned whether he was a man or woman and ultimately made him leave the clinic with no treatment (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).

23. On May 12, 2014, a gay man who was employed by a family member was fired from his job and not paid four month's salary he was owed after it was revealed that he was gay (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
24. On May 14, 2014, the police rescued a bisexual man from a mob, which had locked him in a house and assaulted him (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
25. On May 28, 2014, a transwoman was attacked by six strangers (five men and a woman). The six assailants accosted the victim and taunted her about her appearance (her pierced ears and the manner of wearing trousers). The assailants beat up the victim saying that she and her neighbors who usually moved with her were gay (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
26. On June 5, 2014, a landlord evicted a transwoman from her rented room because of her gender identity. This was after the landlord had made accusations on several occasions that she was gay. She was given two weeks' notice (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
27. On July 9, 2014 (reported), police in Pader district arrested five people suspected to be promoting the act of homosexuality in the district (Owot, Daily Monitor, July 9, 2014).
28. On September 7, 2014, the business community in Mbarara evicted a gay man from his market stall for being gay. This left him with no work to earn a living (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
29. On September 27, 2014, a gay man was arrested at his home in Salaama after neighbors complained to the police that he was homosexual (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
30. On September 30, 2014, a gay man was dismissed and denied 4 months' salary from his work place after being accused of being gay. (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
31. On August 17, 2014, four men were evicted at Kasubi after one of their friends they were living with was listed as a homosexual in the Red Pepper tabloid (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
32. On November 11, 2014, a customer slapped a transwoman working at a bar and promised to mobilize other people to beat her up. Later that day, youths started throwing stones at the bar. (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).

33. On November 28, 2014, the police failed to investigate claims where unknown perpetrators assaulted a gay man and left him unconscious and bleeding (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
34. In November 2014, a transman was evicted from his home and expelled from a village due to his gender identity. The landlord gave him only two days to vacate his home (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
35. On December 18, 2014, police arrested a gay man after leaving a gym in Nabweru. Upon his arrest, he was forced into a police car and not given any reason for his arrest. He was later charged with being “rogue and vagabond” and taken to Matugga Court where he was remanded to Buwambo Prison (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
36. In December 2014, a transman was thrown out of his residence in Gayaza after a neighbor had reported him to the religious leaders at a nearby mosque. His parents also dismissed him from home on the same allegations. The parents beat him heavily and tried to bring police to arrest him and put him in jail. (Consortium of Monitoring Violations Based on Sex Determination, Gender Identity and Sexual Orientation, 2015).
37. In January 2015, nine young gay men were attacked by a homophobic mob. The victims were later arrested by police and subjected to ill-treatment while in jail (Morgan, 2015).
38. May 29, 2015, the Ugandan tabloid *Hello* published a front-page article listing alleged lesbians in Uganda, including LGBTI activists (Stewart, 76 Crimes, June 1, 2015).
39. In May 2015, Ugandan tabloid published photos of Ugandans in the UK who attended Pride in Birmingham, England, referring to them as “bum drillers” and to Pride as a “mega sex fest.” Photos included some of the *Out and Proud Diamond African LGBTI Group* (OPDG). (McCormick, Pink News, May 29, 2015).
40. In June 2015, a Ugandan lesbian was granted asylum in UK (McCormick, Pink News, June, 9, 2015). She was forced to undergo “a torturous exorcism” ritual in Uganda and still bears the scars of sharp lacerations on her joints and the trauma of human degradation.

## **B. Impact on Affiliation and Social Support**

As I described above, hiding one’s sexual identity is a social stressor for many reasons, including the psychological damage from not being able to express oneself genuinely, the

cognitive burden on the person having to lie and conceal his or her identity, and the tangible limitations on affiliation and support.

According to a report by Amnesty International (2014), the situation of LGBT people has become worse after the passage of the Anti-Homosexuality Act. LGBT people found that they had to modify their dress and behavior in order to feel safe. The escalation of conditions, and the targeting by the Anti-Homosexual Act of people who are suspected of “homosexuality” regardless of any sexual behavior, has led to fear that can chill any resources that were available to LGBT people before. As Martin, a gay man, said to Amnesty International, “We are intimidated ...we can't fit into society because of [the AHA] ... there is nowhere safe to go” (Amnesty International, 2014, p.51). “We used to be able to go to safe spaces—bars, beaches—but these are now not safe” (p. 52).

In a study of gay and bisexual men in Kampala published in a peer-reviewed journal, researchers found that 45% of the men had not disclosed their sexual orientation to others. As one of the study participants told investigators, “it is my secret life and Uganda is not a free country” (King et al., 2013, p. 4). Another participant described the need to protect family by hiding his gay identity ‘Yeah I want to look acceptable in my mum’s face but indeed I know who I am, I am gay. Yeah, at least I love being me; I don’t want to let the whole public know that I am an MSM. Okay people may see me with guys only and they suspect [...] but won’t be able to exactly know what is going on” (p. 5). As described above, although such hiding of one’s gay or bisexual identity is done to protect against exposure to stigma, it is also a stressor on its own as it prevents association and affiliation with others who may be able to provide the LGBT person with support and affirmation.



It is a particularly injurious aspect of Uganda's social and political environment that not only are LGBT individuals targeted, but also their association and ability to access support is disturbed (and was explicitly criminalized by the Anti-Homosexuality Bill). For example, as reported by Amnesty International, "In February 2012, [prior to the enactment of the AHA] Fr. Lokodo, Minister for Ethics and Integrity, raided a workshop organized by LGBTI activists. The workshop included activities designed to encourage participants to have self-esteem and confidence"(Amnesty International, 2014, p. 66). Activists filed a case against the Minister, "claiming that the raid infringed on their constitutional rights" but the court ruled in favor of the government "citing section 145 of the Penal Code" arguing "the applicants' promotion of prohibited homosexual acts in the impugned workshop would thus amount to incitement to commit homosexual acts and conspiracy to effect and unlawful purpose". The court also found "that the Minister and police acted lawfully in order to "protect public morals", because same-sex sexual activity is illegal under Ugandan law" (p. 66-67).

This can have a devastating effects on the community as a whole as resources that are aimed at providing support become themselves associated with danger of exposure and violence. Public raids, arrests of advocates, and closures of LGBT-friendly service organizations thus hinder access to support and increase the stress experienced by the community by instilling fear and uncertainty and contributing to a sense that there is nowhere to turn for support.

As related in Amnesty International's report on the effect of the Anti-Homosexuality Act, many people told Amnesty International about the effect that the lack of social spaces has had on their lives. Martin said, "When we go to bars, we are able to live free. Not being able to go out – it's like being locked in a cocoon." Another Uganda respondent agreed saying, "We feel bad – we feel like we are held captive." Alice told Amnesty International that this meant that LGBTI



people “no longer see our friends, no longer communicate.” The report stated, “this lack of space has an effect on relationships with friends and partners” (p. 52).

As I described above, coping and social support are key means through which LGBT people can reduce the ill effects of minority stress. In addition to government actions like raiding peaceful meetings, provisions in the law like “aiding and abetting homosexuality” codify and enforce social isolation and add stressors through exposing family, friends or others to criminal penalty. With coping and social support resources severely curtailed both because of the general fear of discovery and the barriers to finding opportunities for affiliation, the harmful impact on health of minority stress increases.

### **C. Impact on health and well-being**

Research has described the high prevalence of HIV infection among MSM in Kampala: with almost 14% prevalence of HIV, much higher than the 4.5% prevalence estimated for all men in the general population (Hladik et al., 2012). Researchers noted in particular that the “illegality of homosexual behavior, human rights abuses, and severe stigma add to the specifics of [Africa’s] HIV epidemic among MSM” (Hladik et al., p. 1). In a study designed to assess the role of the Same-Sex Marriage Prohibition Act in Nigeria, which has similar impact on stigma of LGBT people as did the Ugandan AHA, researchers found negative health effects of anti-homosexuality legislation. In that study of a sample of MSM in Abuja, Nigeria who were interviewed either before or after the passage of the law, the researchers documented increase in a variety of measures, including fear of seeking health care, a sense that there were no safe place to socialize with other MSM, avoidance of seeking care altogether, verbal harassment and blackmail (Schwartz, Nowak, Orazulike, Keshinro, Ake, Kennedy, Njoku, et al, TRUST Study Group, 2015). This research also demonstrates the devastating effects that stigma can have by

discouraging open discussion of one's sexuality with health care providers. HIV-positive men who had disclosed to a health care provider that they were gay or bisexual were significantly more likely to be on recommended effective HIV treatment and significantly more likely to have undetectable viral load (a desired clinical outcome of the treatment) than their peers who have not disclosed to a health care providers that they were gay or bisexual.

Stigma and discrimination against LGB people in Uganda have a detrimental impact on health care utilization and, particularly, HIV treatment and prevention. As the law could prohibit, discourage, or curtail medical treatment and education about HIV and other health issues relevant to the life of LGBT people, it can have severe adverse consequences to the health of Uganda's LGBT population.

The Anti-Homosexuality Act, in particular, with its criminalization of "homosexuality"—that is, one's identity rather than behavior—has escalated the situation for LGBT people in Uganda who, according to one AIDS advocate there, "have gone underground" (Lavers, Washington Blade, February 28, 2014).

One 24-year-old HIV-positive research participant in a study of gay and bisexual men in Kampala expressed this to the researchers (King et al., 2013):

I always go to hospitals and they easily tell that I am gay. I ask for condoms but usually a health worker will tell you to sit down and wait. Then he calls his co-workers, they peep through a window and laugh/ mock you. This makes me feel very bad. So, I find it easier to use my friends to pick up condoms for me. Sometimes, I just go straight and buy them instead of getting them for free from hospitals (p. 5).

Another respondent in the same study (King et al., 2013), a 25-year-old HIV-negative man, said:

Even if I fall sick or get fever, I just stay home without treatment because you can't go to the main referral hospital in Kampala. There, every health worker will object to giving you treatment saying that "he is a homosexual don't work on him" and say many other things. I was told that very many times, about six or eight times. Like when I was assaulted, don't you see here at the ear, there is

(Embunda; scar/ wounds) [...] they neglected and chased me away and I was bleeding and swollen. I came back home and slept and got healed by God's mercy (p. 5).

Both the fear of rejection and internalized homophobia, also a minority stressor, impact the men in this study and lead to avoiding health care services (King et al., 2013), as described by another study participant:

When you go to visit the hospital, they will not attend to you. In fact I hate going to such hospitals. I do self-treatment from home and I usually use tablets. You know I feel ashamed. I will visit the hospital and everybody will despise me. It is the way female health workers treat me, they make me feel angry and resentful to seek treatment. That makes me feel ashamed. Everybody looks at you. You feel you are not part of the society (p. 5-6).

Not only are LGBT people afraid to seek services, the AHA directly leads to the denial of services to LGBT people, the withdrawal of services, and the threat of to inform the police, as is believed to be required by the law. "Provisions in the bill defining and criminalising 'aiding and abetting homosexuality' would punish landlords, healthcare providers, lawyers, and even friends or family, for failure to disclose alleged homosexuality" (Semugoma, Beyrer, & Baral, 2012, p. 174).

Of course, this is in direct conflict with the Hippocratic Oath and professional ethics obligations as applied to health care settings when sexual identity is disclosed (Semugoma, Beyrer, & Baral, 2012). Indeed, since the AHA was enacted, LGBT persons have been denied access to health services and even threatened with arrest when they are suspected of being LGBT. Jay, a 28-year-old transgender activist in Kampala went to see a doctor for a fever. "When the doctor arrived, he also asked, 'Are you a woman or a man?' I told him that I'm a trans man. He said, 'What's a trans man? You know we don't offer services to gay people here. You people are not even supposed to be in our community. I can even call the police and report you'" (Amnesty International, 2014, p. 62).

This has the effect of demolishing health education and services to LGBT populations in Uganda. Such developments are contrary to any standard of population health, which calls for the inclusion of LGBT-specific health interventions, education, and reduction of stigma related to homosexuality as hallmarks of proper public health efforts.

A 2014 report by the United Nations Educational, Scientific, and Cultural Organization (UNESCO) identifying homophobia is one of the causes of the HIV epidemic among men who have sex with men, explaining “homophobia fuels the epidemic, isolating individuals and making them less likely to seek help and support,” whereas “education can help promote positive attitudes towards sexual diversity and the need for changes geared to addressing intolerance and tackling homophobic and transphobic bullying” (p. 22).

The World Health Organization (WHO) recommended that “MSM and transgender people are entitled to full protection of their human rights as stated in the Yogyakarta Principles,” including “the rights to the highest attainable standard of health, non-discrimination and privacy” (published in *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people*; WHO, 2011, p. 29). Furthermore, “punitive laws and law enforcement practices, stigma and discrimination undermine the effectiveness of HIV and sexual health programmes” (p. 29). The WHO concluded, “Long-standing evidence indicates that MSM and transgender people experience significant barriers to quality health care due to widespread stigma against homosexuality and ignorance about gender variance in mainstream society and within health systems,” (p. 29) and that “[s]tigma against homosexuality is a significant cause of barriers to quality health care of MSM” (p. 10).

For example, a cornerstone of HIV treatment and prevention is early detection of HIV in the population through HIV testing. But this too is devastated by the AHA as it places great risks on individuals who are LGB (or MSM), as they might be reported to the police and subject to punishment under the AHA (Semugoma, Beyrer & Baral, 2012).

Specifically, the WHO noted, “legal and policy barriers,” such as criminalization of homosexuality, “play a key role in the vulnerability of MSM” to HIV (p. 10). The WHO report identified such legal conditions as, on one hand, preventing or inhibiting access of MSM to medical and other health service providers, and, on the other hand, “[giving] the police the authority to harass organizations that provide services to these populations” (p. 10). As is evidenced by reports from Uganda, the WHO predicted that MSM may “delay or avoid seeking health, STI or HIV-related information, care and services as a result of perceived homophobia” and “be less inclined to disclose their sexual orientation and other health-related behaviors in health settings that may otherwise encourage discussions between the provider and patient to inform subsequent clinical decision-making” (p. 11).

The developments reported from Uganda are precisely the opposite of what is needed, as the WHO report noted: “The promotion of a legal and social environment that protects human rights and ensures access to prevention, treatment, care and support without discrimination or criminalization is essential for achieving an effective response to the HIV epidemic and promoting public health” (p. 29).

This analysis leads the WHO to recommend that “Legislators and other government authorities should establish and enforce antidiscrimination and protective laws, derived from international human rights standards, in order to eliminate stigma, discrimination and violence

faced by MSM and transgender people, and reduce their vulnerability to infection with HIV and the impacts of HIV and AIDS” (p. 30). Again, these are the all contradicted by the AHA.

### **VIII. Conclusions**

Stigma and prejudice create for LGBT people a social environment that is inhospitable, and an environment that sends a clear message that the LGBT person is unwelcome. With the backdrop of an environment that was already characterized by homophobia in Uganda and where same-sex acts were illegal, the Anti-Homosexuality Bill and later the AHA sent a clear message of rejection that dehumanized LGBT people by making their very identity as LGBT a “spoiled identity.”

The social environment, in particular within the context of discussions about the Anti-Homosexuality Bill, and public rhetoric that assailed LGBT people, for example by erroneously portraying them as dangerous and child molesters who recruit innocent children, precipitated a hostile environment. The Ugandan social environment is an environment that demands of its LGBT citizens vigilance as they seek to protect themselves from potential discrimination and violence. It is an environment where, in an attempt to protect themselves from the stress of this stigma, LGBT people are moved to conceal their sexual identity. It is an environment where stigma and stereotypes, promoted by civil and religious leaders, are internalized by heterosexual and LGBT people alike, leading to further prejudice, discrimination, and violence.

Numerous accounts have shown how this social environment has brought about a host of stressors on LGBT people that in my and other researchers’ work has been described as *minority stress*. Hundreds of research articles have shown that, in addition to the indignities described by numerous LGBT Ugandans, minority stress causes a host of mental and physical health problems, a reduced sense of well-being, an increase in suicides, and an increase in unhealthy

behaviors (such as unsafe sex practices). In addition, the structural stressors brought about by the AHB, whether they are sanctioned by law or incorrectly interpreted by the public and health care providers, have led to the erection of barriers to healthcare for LGBT people.

I declare under penalty of perjury that the foregoing is true and correct.

Los Angeles, CA  
November 2, 2015

A handwritten signature in blue ink that reads "Ilan Meyer". The signature is written in a cursive, flowing style.

Signature: \_\_\_\_\_  
Ilan H. Meyer

# Exhibit A



EXHIBIT A: CURRICULUM VITAE

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§ 5 EDUCATION

Tel Aviv University, Tel Aviv, Israel -- B.A. Psychology, Special Education, 1981

New School for Social Research, New York, NY -- M.A. Psychology, 1987

Columbia University, School of Public Health New York, NY – Ph.D. Sociomedical Sciences/  
Social Psychology 1993,

Dissertation title: *Prejudice and Pride: Minority Stress and Mental Health in Gay Men.*  
Bruce G. Link, Ph.D. Sponsor

**Traineeship**

1987-1992: Pre-doctoral NIMH Fellow in Psychiatric Epidemiology - Columbia University (T32  
MH 13043)

1993 -1995: Postdoctoral Fellow, Health Psychology, The Graduate Center at CUNY

1995 -1996: NIMH Research Fellow in Psychiatry (AIDS), Memorial Sloan-Kettering Cancer  
Center

§ 6 PREVIOUS EMPLOYMENT

Assistant Professor of Clinical Public Health (part-time), Mailman School of Public Health,  
Columbia University, November 1994

Assistant Professor of Clinical Public Health, (full-time), Mailman School of Public Health,  
Columbia University, November 1996

Assistant Professor of Public Health, Sociomedical Sciences (full-time), Mailman School of  
Public Health, Columbia University, September 1998

Associate Professor of Clinical Sociomedical Sciences, Mailman School of Public Health,  
Columbia University, July 2003

Deputy Chair for Masters Programs, Department of Sociomedical Sciences, Mailman School of  
Public Health, Columbia University, February 2004

Visiting Scholar, Russell Sage Foundation, New York, NY 2006 – 2007

Professor of Clinical Sociomedical Sciences, Mailman School of Public Health, Columbia  
University, July 2010

UCLA SERVICE

§ 7 ACADEMIC AND ADMINISTRATIVE TITLES

Williams Senior Scholar for Public Policy, The Williams Institute at UCLA School of Law, July 2011 - Present

§ 8 LAW SCHOOL COURSES TAUGHT

None

§ 9 LAW SCHOOL COMMITTEE MEMBERSHIP

Williams Institute Management Committee

§ 10 LAW SCHOOL--OTHER SERVICE

None

§ 11 OTHER UNIVERSITY TEACHING

**Columbia University Departmental and University Committees**

Doctoral Admissions Committee – 2011

Coordinator, MPH Research Track – till 2002

Coordinator, MPH Admissions 2002 – 2003

MPH Committee 2003 – 2011

Curriculum committee 2003 – 2011

School MPH Admissions Committee 2002 – 2011

Department of Sociomedical Sciences Steering Committee 2007 – 2011

Department of Sociomedical Sciences Subcommittee on Revenue Generation 2008

Mailman School of Public Health Steering Committee, (elected) 2008 – 2011

**Teaching Experience and Responsibilities**

**Courses**

Introduction to Health Psychology (1995 - 2003)

Research Seminar in Gay and Lesbian Issues in Public Health (1997 – 2011)

Stigma, Prejudice and Discrimination as Social Stressors (2004 - 2011)

Masters Integrative Project (2005 - 2011)

Survey Research Methods in Sociomedical Sciences (2009 - 2011)

**Dissertation sponsor**

Lesley Sept (completed 2002) – *Evaluation of a tailored HIV prevention web site*

Parisa Tehranifar (completed 2004) – *African American adolescents perceptions of everyday racism and their psychological responses*—Distinguished Dissertation; Best Dissertation ASA

Paul Teixeira (defense 2007) – *Condom use among gay men: The impact of reactance and affect on safer sex practices*

Alicia Lukachko (defense 2009) – *Racial identity, discrimination, discrimination and religiosity and use of mental health services among African Americans*

**§ 12 ACADEMIC SENATE COMMITTEE MEMBERSHIP**

N/A

**§ 13 ACADEMIC SENATE--OTHER SERVICE**

N/A

**§ 14 OTHER UNIVERSITY SERVICE AND ACTIVITIES**

2013 -- Dissertation committee Saanjh Aakash Kishore, UCLA Psychology

2013 -- Dissertation committee Melissa Boone, Columbia University, Sociomedical Sciences and Psychology

2013 – Dissertation committee Geoffrey Stephen Carastathis, Psychology Edity Cowan University, Australia

**§ 15 ADDITIONAL ACADEMIC AND OTHER APPOINTMENTS**

None

**§ 16 MEMBERSHIPS IN PROFESSIONAL SOCIETIES**

American Public Health Association

American Psychological Association

American Sociological Association

§ 17 SERVICE TO PROFESSIONAL SOCIETIES AND ORGANIZATIONS

American Civil Liberties Union: Position paper on Gender Identity Disorder and Psychiatric Diagnosis (with Sharon Schwartz)

1993 – 2002 Co-Chair - Science Committee, American Psychological Association, Division 44 (Lesbian and Gay Issues)

§ 17a COMMUNITY SERVICE

Gay Men's Health Crisis: Oral Sex & HIV Risk Among Gay Men (with David Nimmons)

1999 – 2000 Member, working group preparing a white paper on LGBT health disparities for consideration by US HHS of inclusion of sexual orientation in Healthy People 2010

1999- 2000 Member Healthy People 2010 workgroup on sexual orientation

2012 (March) -- (Co-authored with J. Pizer, press release) *Uganda Bill Concerning Same-Sex Relationships and Human Rights Advocacy.*

2012 (March 12) -- (Co-authored with J. Pizer, press release) Analysis and Data On Tennessee's "Don't Say Gay" Bill.

2012 (March 14) -- (Co-authored with J. Pizer) Letter to Governor Gary R. Herbert, Utah Re: House Bill 363 by Rep. Wright (Sen. Dayton) – *Potential Impacts On At-Risk Youth And Licensed Educational Professionals From Health Information Ban.*

2012 (March 28) -- (Co-authored with J. Pizer, press release) *Extending Marriage To Same-Sex Couples in Illinois Will Have Positive Effects For 23,049 Couples Raising 7,662 Children.*

2012 (May 4) – (Co-authored with J. Pizer) Letter to Missouri House Committee on Elementary and Secondary Education, Jackson Missouri re: HB 2051 (Cookson) – *Potential impacts on at-risk youth and licensed education professionals from ban on information about sexual orientation, including about the existence of lesbian, gay, bisexual and transgender people.*

2013 (May 14) – *Promoting the Well-being of Gay and Bisexual Male and Transgender Youth of Color –Working Together for Action.* A summit organized by the Williams Institute, with support from the Liberty Hill Foundation. Organized meeting and presented *Project Access - Recommendations for Serving GBTQ Male Youth of Color.*

§ 17b CONSULTING ACTIVITIES

Expert witness testimony in Perry v. Schwarzenegger, 704 F. Supp.2d 921 (N.D. Cal. 2010);

Expert report – Written testimony in application for asylum, withholding of removal, and/or

withholding under the convention against torture. Removal proceedings before Immigration Judge, United States Department of Justice, Executive Office for Immigration Review (2010);

Expert testimony before the United States Commission on Civil Rights briefing on peer-to-peer violence and bullying in K-12 public schools (2011);

Expert report -- Written testimony in hearing before Immigration Judge on the validity of asylum granted to bisexual man, United States Department of Justice, Executive Office for Immigration Review (2012);

Expert Consultation -- Charles Patrick Pratt, et al. vs. Indian River Central School District; Indian River Central School District Board of Education (2013). Case settled prior to trial.

Expert Declaration – Garden State Equality v. Doe, Superior Court of New Jersey, MER L-1729-11.

Expert Declaration – Cleopatra De Leon, et al. v. Rick Perry, Civil Action No. 5:-13-cv-982. United States District Court for the Western District of Texas, San Antonio Division.

Expert Declaration – Washington State v. Arlene Flowers, Inc. No. 13-2-00871-5

Expert Consultant – Pat PJ Newton/ Shannon Mississippi Gay Bar

Expert witness – U.S. v. Gary Douglas Watland, Defendant. Criminal Action No. 1:11-cr-00038-JLK-CBS.

Expert Declaration – European Court of Human Rights. Bayev v. Russia (No. 67667/09), Kiselev v. Russia (No. 44092/12), and Alekseyev v. Russia (No. 56717/12)

#### § 17c OTHER PROFESSIONAL ACTIVITIES

2001 – 2011 Faculty, the Center for Gender, Sexuality and Health, Department of Sociomedical Sciences, Mailman School of Public Health, Columbia University

2003 Member, Working Group – Men who have sex with men (MSM) of color summit, Los Angeles, CA, May 29-30

2004 – 2011 Faculty, The Robert Wood Johnson Foundation Health & Society Scholars Program at Columbia University

2004 Leader, Working Group on Stigma, prejudice and discrimination. The Robert Wood Johnson Health and Society Scholars Program at Columbia. Mailman School of Public Health, Columbia University

2008 – 2011 Faculty, The Center for the Study of Social Inequalities and Health, Mailman School of Public Health, Columbia University

2008 – 2011 Faculty -- New York State Psychiatric Institute, HIV Center for Clinical and Behavioral Studies

2008 – 2011 Faculty -- Center for Population Research in LGBT Health, The Fenway Institute

2013 – Present Affiliate, California Center for Population Research

## **Mentorships**

### **Past**

John Blosnich. West Virginia University, Public Health Sciences, Social & Behavioral Theory. Mentor through Center for Population Research in LGBT Health (Fenway Institute, Boston, MA).

Richard Nobles. Department of Psychology, University of Washington. Consultant on NIMH individual NRSA grant.

Keren Lehavot. Department of Psychology, University of Washington. Consultant on NIMH individual NRSA grant.

Natasha Davis. Columbia University Teachers College. Mentor on supplemental diversity NIMH grant (MH066058).

Edward Alessi (NYU) – Dissertation: *Association of stressful life events and with posttraumatic stress disorder (PTSD) in a racially and ethnically diverse sample lesbian, gay, bisexual (LGB), and heterosexuals.*

David Frost (CUNY Graduate Center) – Dissertation: *Stigma, intimacy, and well-being: A personality and social structures approaches*

David Barnes -- Columbia University Mailman School of Public health, Department of Epidemiology, Psychiatric Epidemiology Training program.

Naa Oyo Kwate, Ph.D., Research Scientist, Postdoctoral Award, Department of Defense, Breast Cancer Research Program, Department of Defense

Jennifer Stuber, Ph.D., Scholar, Robert Wood Johnson Foundation Health and Society Scholars

Kimberley Balsam, Ph. D., University of Washington. Consultant, NIMH K-Award application

Carolyn Wong, Ph.D., University of Southern California. Consultant, K-Award application.

José A. Bauermeister, MPH, PhD, University of Michigan, Mentor, K-Award application.

Huso Yi, Ph.D., Columbia University, HIV Center, Mentor, K-Award application.

Rahwa Haile, Ph.D., Columbia University, HIV Center for Clinical and Behavioral Studies, Mentor.

Tracy McFarlane, Ph.D., Columbia University, Psychiatric Epidemiology Training Program, Mentor.

Laura Durso, Williams Institute UCLA School of Law, post-doctoral fellow.

Ethan Meirish, Ph.D., Boston College, Fenway mentorship program

Ashley Borders, Ph.D., Assistant Professor, Department of Psychology, The College of New Jersey

### **Current**

Johnny Berona, University of Michigan, Clinical Psychology

Carlos Pavao, Doctoral Student, Health Promotion & Community Health Sciences School of Rural Public Health, Texas A&M University Health Science Center

Annesa Flentje, Ph.D., Clinical Psychology Fellow, University of California, San Francisco San Francisco General Hospital, Department of Psychiatry

### **§ 18 SERVICE ON EDITORIAL BOARDS/EDITORIAL SERVICE TO SCHOLARLY PUBLICATIONS**

1993 – present Ad hoc reviewer for leading scientific journals, including (partial list), AIDS Education and Prevention: An interdisciplinary Journal, American Journal of Public Health, Archives of General Psychiatry, Epidemiology, Journal of Health and Social Behavior, Journal of Consulting and Clinical Psychology, Journal of Counseling Psychology, Sex Roles: A Journal of Research, Women and Health, Self and Identity, Developmental Psychology

2000 – 2001 Guest Editor, American Journal of Public Health, Special Issue on LGBT Health, published June 2001

2006 Co-editor, Social Science & Medicine, Special Issue on Prejudice, stigma, and Discrimination in Health

2009 – 2012 Editorial Board – Journal of Health and Social Behavior (ASA Journals)

2013 – present Editorial Board – Journal of LGBT Health (Mary Ann Liebert, Inc.)

2013 – present Consulting Editor – Journal of Sexual Orientation and Gender Diversity (APA Journals)

§ 19 SERVICE TO EDUCATIONAL AND GOVERNMENTAL AGENCIES

2003 Member, Working Group -- Workplace discrimination research and prevention, National Institute of Occupational Safety and Health (NIOSH), Cincinnati, OH, September 29-30

§ 20 INVITED LECTURES, PAPERS AT MEETINGS, AND SIMILAR ACTIVITIES

**Conference Presentations (partial list)**

Meyer, I.H. Experience from a community-based asthma intervention. Working Together to Combat Urban Asthma. Proceedings of a Conference hosted by the Center for Urban Epidemiologic Studies at the New York Academy of Medicine. New York, May 4 and 5, 1998.

Meyer I.H., Copeland L., Findley S., McLean D.E., Richardson L., Ford J.G.: The Harlem asthma knowledge questionnaire. Paper presented at the International Conference of the American Thoracic Society, Chicago, IL. April 24 - 29, 1998

Meyer, I.H., Richardson, L., Findley, S., McLean, D., Trowers, R., Ford, J.G. (1999). Predictors of frequent asthma-related emergency department use in Harlem. American Journal of Respiratory and Critical Care Medicine, 159: (3) A129-A129, Suppl. S.

Ford, J.G., Li, Y., Meyer, I.H., Dave, C., De Graffinreidt, D. (1999). beta(2)-adrenoreceptor B16 and B27 polymorphisms and asthma severity. American Journal of Respiratory and Critical Care Medicine, 159: (3) A31-A31, Suppl. S.

Meyer I.H. Reducing Disparities in Asthma Care: Are We Doing Enough?. The 96th International Conference of the American Thoracic Society, Toronto, Canada. May 5 –10, 2000

Meyer I.H., Fagan J., Sternfels P., Foster K., Dave C., Ford J: Asthma-Related Limitation in Sexual Functioning among Emergency Department Users. The 96th International Conference of the American Thoracic Society, Toronto, Canada. May 5 –10, 2000

Meyer, I.H. Minority stress and mental health in lesbian and gay populations. Paper presented at the 26th Annual Meeting of the International Academy of Sex Research, Paris, France. June 21 – 24, 2000.

Meyer, I.H. Epidemiology of mental health in gay men: What do we know and what do we need to know? Paper presented at the Gay Men's Health Summit, Boulder, Colorado. July 19 – 23, 2000.

Meyer, I.H., Community outreach for asthma care in Harlem: Broad based community, clinic, and research collaboration. Paper presented at the Annual Meeting of the American Association of Public Health, Washington, DC, November 13, 2000.

Meyer, I.H., Gay and bisexual men's health: What we know, what we need to know, what we need to do. Paper presented at the Annual Meeting of the American Association of Public Health, Washington, DC, November 15, 2000.



Meyer, I.H., Rossano, L., Ellis, J., & Bradford, J. Use of a brief telephone interview to identify lesbian and bisexual women in random digit dialing sampling. Paper presented at the 56th Annual Conference of the American Association of Public Opinion Research, Montreal, Canada, May 17 – 20, 2001.

Meyer, I.H. (2003). Prejudice as stress: Conceptual and measurement problems. Paper presented at the Eighth International Conference on Social Stress Research, Portsmouth, NH, April 2002.

Meyer, I.H. (2003). Minority stress and mental health in lesbians, gay men, and bisexuals. Paper presented at the annual meeting of the American Psychiatric Association, San Francisco, May 17 – 20, 2003.

Meyer, I.H. (2004). Expectations of stigma as a stressor in minority populations. Paper presented at the Ninth International Conference on Social Stress Research, Montreal, Canada, May 28 – 31, 2004.

Meyer, I.H. (2005). LGBT health research: Theoretical issues and research ethics. Enhancing the Health and Well-being of LGBT Individuals, Families and Communities: Building a Social Work Research Agenda. Symposium of the Institute for the Advancement of Social Work Research, Washington, D.C., June 23-24, 2005

Meyer, I. H. (2005, August). *Intersectionality in LGB health research*. Paper presented at the annual convention of the American Psychological Association (APA), Washington, DC.

Meyer, I. H. (2006, March). *Stress and mental health lesbian, gay, and bisexual individuals*. Paper presented at Temple Concord, Binghamton, NY (co-sponsored by Binghamton University, Pride and Joy Families, and the Temple Concord Outreach Committee).

Meyer, I. H. (2006, March 23). *Social stress, identity, and mental health in diverse lesbian, gay, and bisexual populations*. Paper presented at Binghamton University, Binghamton, NY.

Meyer, I. H. (2006, May 18). *Race, gender, and sexual orientation variability in exposure to stress related to prejudice*. Paper presented at the Psychiatric Epidemiology Training Seminar, Mailman School of Public Health, Columbia University.

Meyer, I. H., Schwartz, S., Stirratt, M. J., & Frost, D. M. (2006, August). *Identity, stress, and coping in lesbian, gay, and bisexual populations*. Paper presented at the annual convention of the American Psychological Association (APA), New Orleans, LA.

Frost, D. M., & Meyer, I. H. (2006, August). *Internalized homophobia as a predictor of intimacy-related stressors among gay, lesbians, and bisexual individuals*. Poster presented at the annual convention of the American Psychological Association (APA), New Orleans, LA.

Meyer, I.H. (2006, October). *Social stress related to prejudice and discrimination as a cause of mental disorders: Conceptual issues and research findings*. Paper presented at the Yale University Psychology Colloquium.

Meyer, I. H., Dietrich, J., & Schwartz, S. (2006, November). *Prevalence of DSM-IV disorders in diverse lesbian, gay, and bisexual populations*. Paper presented at the annual convention of the American Public Health Association (APHA). Boston, MA.

Frost, D. M., Dietrich, J., Narvaez, R. F., & Meyer, I. H. (2006, November). *Improving community sampling strategies of diverse lesbian, gay, and bisexual populations*. Paper presented at the annual convention of the American Public Health Association (APHA). Boston, MA.

Gordon, A. R., & Meyer, I. H. (2006, November). *Gender nonconformity as a target of prejudice, discrimination, and violence against LGB individuals*. Paper presented at the annual convention of the American Public Health Association (APHA), Boston, MA.

Kertzner, R. M., Meyer, I. H., Frost, D. M., & Stirratt, M. J. (2006, November). *Psychological and social well-being in lesbians, gay men, and bisexuals: The effects of age, sexual orientation, gender, and race*. Paper presented at the annual convention of the American Public Health Association (APHA), Boston, MA.

Meyer, I.H. (2008, July) Social stress and mental health outcomes in lesbians, gay men and bisexuals. Paper presented at the XXIX International Congress of Psychology, Berlin, Germany.

Meyer, I.H. (2008, August). Random versus venue-based community sampling of lesbians, gay men, and bisexuals, Paper in a symposium titled *Innovative research methodologies for advancing LGBT scholarship*. American Psychological Association 2008 Annual Convention, Boston MA

Frost, D.M. & Meyer, I.H. (2008, August). Social Support Networks among Diverse Sexual Minority Populations. Poster presented at the American Psychological Association 2008 Annual Convention, Boston MA

Frost, D.M., Lehavot, K., & Meyer, I.H. (2011, August). Minority Stress and Physical Health among Sexual Minorities. Poster presented at the American Psychological Association 2011 Annual Convention, Washington, DC.

Meyer, I.H. (Naomi Goldberg first author) (2012, May 4). Intimate Partner Violence in LGB Populations: Data from the California Health Interview Survey. Population Association of America, San Francisco, CA.

Meyer, I.H. (Discussant) (2013, July 31) -- Emerging Directions and Novel Applications of Minority Stress Theory. Presented at the American Psychological Association 2013 Annual Convention, Honolulu, HI.

Meyer, I.H. (Conversation Hour) (2013, August 2) – Is Minority stress theory still relevant to LGB populations? A Discussion. Presented at the American Psychological Association 2013 Annual Convention, Honolulu, HI.

# **Invited Presentations (partial list)**

Meyer, I.H. (2004, March 26). *Minority Stress: The Impact of Stigma, Prejudice, and Discrimination on the Mental Health of LGB populations*. Gay Men's Health Center, New York, NY.

-- (2004, September 28). *Stress, identity, and mental health in minority populations*. Sociomedical Sciences Seminar, Mailman School of Public Health, Columbia University.

-- (2004, October 7). *Prejudice, Identity, and Resilience in Minority Mental Health*. Rutgers University.

-- (2006, February 7). *Stress, identity, and mental health: overview*. Sociomedical Sciences Seminar, Mailman School of Public Health, Columbia University.

-- (2006, March). *Stress and mental health lesbian, gay, and bisexual individuals*. Temple Concord, Binghamton, NY (co-sponsored by Binghamton University, Pride and Joy Families, and the Temple Concord Outreach Committee).

-- (2006, March 23). *Social stress, identity, and mental health in diverse lesbian, gay, and bisexual populations*. Binghamton University, Binghamton, NY.

-- (2006, May 18). *Race, gender, and sexual orientation variability in exposure to stress related to prejudice*. Psychiatric Epidemiology Training Seminar, Mailman School of Public Health, Columbia University.

-- (2006, October 12). Clinical lunch talks, Department of Psychology, Yale University.

-- (2006, November 1). *Social stress related to prejudice and discrimination as a cause of mental disorders*. Temple University, Philadelphia, PA.

-- (2007, February 11). Russell Sage Foundation, Scholars Seminar. *Stress related to prejudice as a cause of mental disorders*. Russell Sage Foundation, New York, NY

-- (2007, September 20). *Stress, Identity, and Health in Diverse NYC LGB Communities*. HIV Center for Behavioral Studies, New York State Psychiatric Institute, New York, NY

-- (2007, June 5). Invited Keynote Address, The NIH 11th Annual Noon-in-June Program: An Observance of Gay, Lesbian, Bisexual & Transgender Pride Month at the National Institutes of Health. *The impact of prejudice on the mental health of lesbians, gay men, and bisexuals*. Bethesda, MD

-- (October, 2007). *Stress, Identity, and Mental Health in Diverse NYC LGB Communities?* St. Luke-Roosevelt Hospital, New York, NY

-- (2007, November 14). *Stress exposure and mental health outcomes: Are women disadvantaged?* Johns Hopkins University, Baltimore, MD.

- (2007, November 29). Invited speaker: AAPOR NY symposium on lesbian and gay men. *The Impact of Prejudice and Discrimination on the Mental Health of LBG Populations*. Hunter College, New York, NY
- (2008, January 6). Trevor Project suicide prevention helpline . *Staff training: Minority stress and health of LGB persons*. New York, NY
- ( 2008, April 25). Invited speaker: *Minority stress and LGBT public health*. Breaking the Silence: LGBT Research at Columbia and Beyond, Columbia University, New York, NY
- (2008, May 29). Keynote Speaker, Maine LGBTI Health Summit: Challenges, Opportunities, Change. *Social Stress and Health Disparities of LGBTI populations*. Augusta, ME
- (2008, September 17) Personality/Social Psychology Colloquia. *Social Psychology and Minority Stress Models*. Graduate Center of the City University of New York. New York, NY.
- (2008, October 17). *Prejudice, Social Stress and Mental Health*. Psychiatry Grand Rounds. Memorial Sloan-Kettering Cancer Center, New York, NY.
- (2009, February 27). *LGBT public health*. UNC Minority Health Conference. UNC Gillings School of Global Public Health, Chapel Hill, NC
- (2009, March 18). *Minority (Social) Stress*. Drexel University, Philadelphia, PA.
- (2009, May 1). Keynote Speaker. Queer Health Task Force Conference, Columbia University, Mailman School of Public Health.
- (2009, September 22). Gender, Sexuality, and Health seminar. *Social stress as a cause of mental disorder: research findings and reflections on a theory*. Columbia University, Mailman School of Public Health, Department of Sociomedical Sciences. New York, NY
- (2009, October 8). Robert Wood Johnson Foundation Investigator Awards in Health Policy Research, 2009 Annual Meeting. With Naa Oyo Kwate. *On the content of our character: The myth of meritocracy and African American health*. San Diego, CA
- (2009, December 1). Keynote Speaker. World AIDS Day Symposium *Minority Stress Theory, Findings, and Implications for HIV/AIDS Prevention with Racial/Ethnic Minority Gay and Bisexual Men*. University of California San Francisco, Parnassus Campus. San Francisco, CA
- (2009, December 3). *Social stress as a cause of mental disorders: Research findings and reflections on a theory*. Palo Alto University, Palo Alto, CA
- (2010, March 22). Invited address. *Mental Health: Stress and Protective Factors*. Institute of Medicine, Board on the Health of Select Populations. Committee on Lesbian, Gay, Bisexual, and Transgender Health: Issues and Research Gaps and Opportunities. Washington, DC

- (2010, April 27). Invited Speaker. *Bring gay back to the MSM health crisis*. Invited address, The Sexual Health of Gay Men and other MSM: HIV/STD Prevention Plus Conference, The Fenway Institute, Fenway Health, Boston, MA.
- (2010, May 5). Keynote Speaker. LGBT Resiliency: From Trauma To Policy, Boston College, Boston, MA
- (2010, May 7). Invited Speaker. *Sexual Orientation and Disparities in Mental Health*. Kellogg School of Management, Northwestern University, Chicago, IL.
- (2010, June 28 – July 1). Lecturer. National Sexuality Resource Center at San Francisco State University Summer Institute. San Francisco, CA
- (2010, August 11). Lecturer. Boston University/Fenway Health Summer Institute, Boston, MA
- (2010, August 13). Invited Speaker. *Marriage Inequality, Structural Stigma, and Health: Lesbian, Gay, and Bisexual People*. American Psychological Association, Presidential program on Marriage Equality. San Diego, CA
- (2010, September 21). Research, advocacy, and the constitutional challenge to the Prop 8 ban on gay marriage in California. Department of Sociomedical Sciences, Columbia University Mailman School of Public Health.
- (2010, September 21). Bring gay back to the MSM health crisis. New York City HIV Prevention Planning Group. New York, NY
- (2010, December 1). Invited Speaker. *Perry v. Schwarzenegger* and minority stress. Rutgers University, Women and Gender Studies Department.
- (2010, December 6). Minority Stress and Mental Health in LGB Populations. The Charles R. Williams Institute on Sexual Orientation Law, University of California Los Angeles, Los Angeles, CA
- (2011, February 9). Invited Speaker. Research, advocacy, and the constitutional challenge to the Prop 8 ban on gay marriage in California. CUNY Graduate Center, Social/Personality Psychology. New York, NY
- (2011, February 22). Discussant, Libby Adler's paper entitled: Just the Facts: The Perils of Expert Testimony in Gay Rights Litigation. Columbia University Law School.
- (2011, March 16). Invited Speaker. Institute on Urban Health Research Northeastern University.
- (2011, March 25). Group leader, Intersectionality Working Group. Fenway Institute, Boston.

-- (2011, April 8). Pride & Joy Training Day, Training for health care professionals in Upstate and Western New York State on mental health issues of LGBT populations. Pride and Joy Families Weekend Conference, Rochester, NY.

-- (2011, April 9). Invited Speaker: *Research, Advocacy, and the Constitutional Challenge to the Prop 8 Ban on Gay Marriage in California*. 2011 Pride and Joy Families Weekend Conference, Rochester, NY.

-- (2011, May 13). Testimony before the U.S. Commission on Civil Rights *Peer-to-Peer Violence and Bullying: Examining the Federal Response*. Washington, DC.

-- (2011, May 29-31). Invited address. Quantifying Intersectionality Dialogue. Spring Learning Institute on Intersectionality. Simon Fraser University, Vancouver, BC.

-- (August 10, 2011). Minority Stress Research and the Constitutional Challenge to the Prop 8 Ban on Gay Marriage in California. Fenway Summer Institute, Boston, MA

-- (2011, September 8-10). Invited Speaker. Using Social Science Research in LGBT Rights Litigation and Public Policy Advocacy, Lavender Law conference, Los Angeles, CA

-- (2011, October 21). Invited Speaker. Social Science and Public Health in LGBT Law and Public Policy. Loyola Law School Los Angeles, CA Symposium LGBT identity and the law.

-- (2011, November 1). Keynote Address. Minority Stress and the Health of Sexual Minorities. 7th British Columbia Gay Men's Health Summit Health & Sexual Rights, Vancouver, BC, Canada

- (2012, February 9). Minority Stress and the Health of Sexual Minorities Lecture at Diversity Science Initiative. UCLA Psychology Department, Los Angeles, CA

- (2012, February 18). The health impact of homophobic school environment on LGBT youth. CESC&L Supporting Students ~ Saving Lives conference, San Diego, CA

- (2012, February 22). What happened to the Employment Non-Discrimination Act (ENDA) and how employment discrimination still burdens the LGBT community? Williams Institute Lecture Series, West Hollywood, CA

- (2012, April 5). Why LGBT public health? National Public Health Week 2012 Queers for Public Health & Students of Color for Public Health. UCLA School of Public Health, Los Angeles, CA

- (2012, April 20). Marriage Equality for Same-Sex Couples: Science and the Legal Debate. Keynote panel, Minnesota Psychological Association, Minneapolis, MN.

**Guest Lectures (2011 – Present only)**



Lecturer. Boston University/Fenway Health Summer Institute, Boston, MA (2010 – 2013)

Guest lectures– Department of Community Health Sciences, Fielding School of Public Health (2012 and 2013) Chandra Ford

Guest lecture -- Introduction to LGBT Studies ,UCLA (2012) James Schultz

Guest Lecture (Panel) – HIV Legal Needs Assessment, UCLA School of Law (2013) Brad Sears

Guest lecture -- Department of Social Welfare, UCLA Luskin School of Public Affairs (2013) Ian Holloway

Guest lecture – Education Department, UCLA (2013, 2014) Stuart Biegel

#### §20a OTHER PROFESSIONAL ACTIVITIES

#### §21 AWARDS, HONORS, COMMENDATIONS

Distinguished Dissertation - Columbia University, Graduate School of Arts and Sciences

Barbara Snell Dohrenwend Award for published/publishable paper

Marisa De Castro Benton Dissertation Award for outstanding contribution to the Sociomedical sciences - Columbia University

Honorable Mention, Best Dissertation - American Sociological Association, Mental Health Section

Mark Freedman Award for outstanding research on lesbian/gay issues - Association of Lesbian & Gay Psychologists

Distinguished Scientific Contribution Award -- American Psychological Association Division 44.

May 2010 – Inaugural Faculty Mentoring Award – Department of Sociomedical Sciences, Columbia University's Mailman School of Public Health

August 2011 -- Outstanding Achievement Award – The Committee on Lesbian, Gay, Bisexual, and Transgender Concerns 2011

August 2013 – Distinguished Professional Contribution Award – The Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Association.

§22 FELLOWSHIPS AND RESEARCH GRANTS

1. Project Title: Random Digit Dialing Survey of Gay/Bisexual Men

Project #, PI, and dates: Meyer, 5/1/95 – 5/1/96

Source and support amount: American Suicide Foundation, New York State Psychiatric Institute, \$5,000

Role: Principal Investigator

2. Project title: Decreasing the Need for Emergency Asthma Care in Harlem

Project #, PI, and dates: 5R01HL051492, Ford, 9/1/96 – 7/31/99

Source and support amount: National Heart, Lung, and Blood Institute \$1,800,000 (est.)

Role: Project Director

3. Project Title: Columbia Center for Children's Environmental Health

Project #, PI, and dates: Perrera, 8/1/98 – 7/31/03

Source and support amount: National Institute for Environmental Health Sciences, \$901,730 (annual)

Role: Co-Investigator

4. Project Title: Community Outreach for Asthma Care in Harlem

Project #, PI, and dates: Meyer, 8/1/99 – 10/1/00

Source and support amount: New York State Department of Health, \$350,000

Role: Principal Investigator

5. Project Title: Head Start for Asthma

Project #, PI, and dates: Ford, 9/30/99 – 9/29/02

Source and support amount: Centers for Disease Control and Prevention (CDC), \$350,000 (annual)

Role: Co-Investigator

6. Project Title: Survey of Women's Health and Sexuality

Project #, PI, and dates: Meyer, 3/1/00 – 3/1/01



Source and support amount: Gay and Lesbian Medical Association, Lesbian Health Fund, \$7,500

Role: Principal Investigator

7. Project Title: Vulnerabilities and strengths in the face of sexual prejudice in lesbians, gay men, and bisexuals

Project #, PI, and dates: Meyer, 10/31/01 – 10/30/03

Source and support amount: American Psychological Foundation, \$50,000

Role: Principal Investigator

**8. Project Title: Prejudice as Stress – writing manuscript**

Project #, PI, and dates: 5 G13 LM007660, Meyer, 9/30/02 – 9/29/05

Source and support amount: National Library of Medicine, \$163,500

Role: Principal Investigator

**9. Project Title: Measurement of Major Stressful Events over Life Courses**

Project #, PI, and dates: R01MH059627, Dohrenwend, 2/1/03 – 2/ 31/04

Source and support amount: National Institute of Mental Health, \$276,000 (annual)

Role: Co-Investigator

**10. Project Title: Stress, Identity, and Mental Health in Diverse Minority Populations**

Project #, PI, and dates: R01 MH066058, Meyer, 4/1/03 – 3/31/07

Source and support amount: National Institute of Mental Health, \$1,861,700

Role: Principal Investigator

**11. Project title: Stigma, prejudice and discrimination in public health.**

Project #, PI, and dates: Meyer, 9/1/04 – 5/31/06

Source and support amount: The Robert Wood Johnson Health & Society Scholars at Columbia University, \$42,000

Role: Principal Investigator

**12. Project Title: Cultural and Contextual Determinants of Alcohol Use Among African American Women: A Multidisciplinary Approach to Breast Cancer Risk**

Project #, PI, and dates: BC031019, Kwate, 9/1/04 – 8/31/07

Source and support amount: Department of Defense, Breast Cancer Research Program, \$402,206

Role: Mentor to Dr. Kwate, PI.

**13. Project Title: Diversity supplement doctoral student, Natasha Davis**

Project #, PI, and dates: Supplement to 5 R01 MH066058, Meyer, 4/22/05 – 3/31/07

Source: National Institute of Mental Health, \$42,000 (est. annual)

Role: Principal Investigator

**14. Project Title: Prejudice and stress in minority populations**

Project #, PI, and dates: Meyer, 9/1/07 – 7/31/07

Source of support and amount: Russell Sage Foundation,

Role: Visiting Scholar

**15. Project title: HIV Center for Clinical and Behavioral Studies**

Project #, PI, and dates: P30 MH43520 (Ehrhardt) 02/01/08 - 01/31/11

Source and support: NIMH \$1,483,545

Role: Investigator

Project description: This large multidisciplinary AIDS research center focuses on HIV prevention science among neglected populations at risk for HIV infection, with a commitment to underserved inner-city populations and innovative research based on new scientific approaches to prevention that emphasize sexual risk and its broader context of gender, ethnicity, and culture. Research also focuses on interventions with HIV-infected populations, including those for stress, coping, and medical adherence.

**16. Project title: Minority HIV/AIDS Research Initiative (MARI): Sexual risk-taking among young Black men who have sex with men: exploring the social and situational contexts of HIV risk, prevention, and treatment**

Project #, PI, and dates: U01 PS 000700-01 (Wilson) 9/30/07 – 6/30/2011

Source and support: CDC, \$592,720

Project description: The 3-year project will research contextual risk and protective factors linked to HIV risk among young Black men who have sex with men (BMSM).

Role: Mentor, Co-investigator

**17. Project title: Developmental infrastructure for population research**

Project #, PI, and dates : Bradford (PI) 2007-2012

Source and support: NICHD R21HD051178 – *No funds requested for faculty*

Role: Research Faculty

**18. Project title: On the content of our character: The myth of meritocracy and African American health.**

Project #, PI, and dates: July 1, 2009 – December 14, 2012

Source and support: Robert Wood Johnson Foundation Investigator Award in Health Policy. \$202,353 (\$57,783 to UCLA for 2012)

Role: Co-PI

Project description: The proposed study aims to investigate some of the ill health effects of meritocratic ideology (MI). We propose to describe the distribution and variation of MI in the United States across historical periods and geographic regions and to assess the relationship between MI ideologies and other ideologies that more explicitly advance inequality. We then aim to describe narratives of MI among African Americans and assess their impact on their physical and mental health.

**19. Project title: ACCESS: Assessing the experiences and needs of gay, bisexual, and transgender youth of color**

Project #, PI, and dates: Ilan Meyer 2011 – 2012

Source of Support: California Endowment, Liberty Hill Foundation, \$35,000

Role: PI

**20. Project title: Needs Assessment of People with HIV/AIDS**

Project #, PI, and dates: Brad Sears, 2013-2014

Source of Support: Ford Foundation, *part of \$250,000 to the Institute*

Role: Co-PI (with Brad Sears)

**21. Project title: Sexual victimization of men**

Project #, PI, and dates: Brad Sears, 2013-2014

Source of Support: Ford Foundation, *part of \$250,000 to the Institute*

Role: Co-PI (with Brad Sears)

**22. Project title: Generations: Identity Stress and Health in Three Cohorts of LGB individuals**

Project #, PI, and dates: 5R01HD078526, Ilan H. Meyer, 09/04/2014 – 05/31/2019

*Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD), \$3,402,550

**24. TransPop: U.S. Transgender Population Health Survey**

Project #, PI, and dates: 3R01HD078526-01A1S1, Ilan H. Meyer, 3/25/2015 – 3/24/2016

*Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD, supplement) -- \$285,000

**25. Sampling LGBT populations in large population samples: sensitivity and specificity**

Project #, PI, and dates: 3R01HD078526-02S1, Ilan H. Meyer, 3/25/2015 – 3/24/2016

NIH Office of Research on Women's Health (ORWH) -- \$200,000

**26. Research supplement to support diversity – Alexander Martos “LGBT health services delivery”**

Project #, PI, and dates: 3R01HD078526-02S2, Ilan H. Meyer, 9/4/15 – 5/31/2018

*Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD, supplement) -- \$224,892

**Research Consultant (Current only)**

1. Jeremy T. Goldbach, Ph.D., LMSW, (PI) Assistant Professor, University of Southern California School of Social Work. *USC Lesbian, Gay, and Bisexual Adolescent Study* and NIH Application for same.
2. Bruce Link and Mark Hatzenbuehler (Co-PIs). *Structural Stigma as a Source of Disparities in Critical Social, Economic, and Health Domains* NSF application.
3. Allen J. LeBlanc, Ph.D., (PI) San Francisco State University, Department of Sociology,

Health Equity Institute, *Minority Stress and Mental Health among Same-Sex Couples*

4. Phillip L. Hammack, Ph.D., (PI) University of California, Santa Cruz, William T Grant *Empowering Settings as Vehicles for Social, Political, and Psychological Change among Sexual Minority Youth.*

5. Jaime Barrientos-Delgado, Ph.D., Escuela de Psicología, Universidad Católica del Norte, *Beyond Homophobia: Quality of Life and Post-Traumatic Growth (PTG) as a Response to Gay and Lesbian Minority Stress in Chile*

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### WORK IN PROGRESS

Wilson, P.A., Meyer, I.H., Antebi, N., Boone, M.R., Cook, S.H., & Cherenack, E. (in review). *Profiles of Resilience and Psychosocial Outcomes among Young Black Gay and Bisexual Men.*

Durso, L.E., Kastanis, A., Wilson, B.D.M, & Meyer, I.H. (in review). *Service Needs of Sexual Minority Male Youth of Color.*

Frost, D.M., Meyer, I.H., Schwartz, S. (in review). *Social Support Networks among Diverse Sexual Minority Populations.*

Meyer, I.H. (in preparation for journal submission). *Is Minority Stress Theory Still Relevant to LGB populations? Critiques and Research Recommendations.*

### PUBLISHED WORK

#### Books:

Meyer, I.H. & Northridge, M.E. (Eds.). (2007). *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations.* New York: Springer.

#### Chapters:

1. Meyer, I.H., Frost, D.M., & Nezhad, S. (2014). Minority stress and suicide in lesbians, gay men, and bisexuals. In Peter B. Goldblum, Dorothy Espelage, Joyce Chu, & Bruce Bongar, (Eds), *The Challenge of Youth Suicide and Bullying* (pp. 177 – 190). New York, NY: Oxford University Press.
2. Meyer, I.H. & Frost, D.M. (2013). Minority stress and the health of sexual minorities. In Charlotte J. Patterson and Anthony R. D’Augelli (Eds.), *Handbook of Psychology and Sexual Orientation* (pp. 252 – 266). NY: Oxford University Press.
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4. Meyer, I.H. & Ouellette, S.C. (2009). Unity and purpose at the intersections of racial/ethnic and sexual identities. In Phillip L. Hammack and Bertram J. Cohler (Eds.), *The story of sexual identity: Narrative perspectives on the gay and lesbian life course* (pp. 79 – 106). NY: Oxford University Press.
5. Meyer, I.H. (2007). Prejudice and discrimination as social stressors. In I.H. Meyer and M.E. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations* (pp. 242 – 267). New York: Springer.

Articles/Editorials:

6. Frost, D.M., Meyer, I.H., & Schwartz, S. (in press). Social Support Networks Among Diverse Sexual Minority Populations. *American Journal of Orthopsychiatry*.
7. Wight, R.G., LeBlanc, A.J., Meyer, I.H., & Harig, F.A. (in press). Internalized Gay Ageism, Mattering, and Depressive Symptoms among Midlife and Older Gay-Identified Men. *Social Science & Medicine*.
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10. Frost, D. M., Meyer, I. H., & Hammack, P. L. (2015). Health and well-being in emerging adults' same-sex relationships: Critical questions and directions for research in developmental science. *Emerging Adulthood*, 3(1) 3-13. DOI: 10.1177/2167696814535915
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#### OTHER

2009 Interview with Dr. Van Nuys

[http://www.mentalhelp.net/poc/view\\_index.php?idx=119&w=9](http://www.mentalhelp.net/poc/view_index.php?idx=119&w=9) or

<http://tinyurl.com/br6ojl>

# Exhibit B

ILAN H. MEYER, PH.D.

EXHIBIT B: DOCUMENTS PROVIDED BY COUNSEL TO THE PLAINTIFFS

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1. FIRST AMENDED COMPLAINT PURSUANT TO FED. R. CIV. P. 15(a)(1)(B) FOR CRIME AGAINST HUMANITY OF PERSECUTION, DEMAND FOR JURY TRIAL, Civil Action 3:12-CV-30051 (MAP). Filed July 13, 2012
2. Videotape deposition of RICHARD LUSIMBO, taken by Defendants, pursuant to notice, held at the offices of DORSEY & WHITNEY, LLP, 51 West 52<sup>nd</sup> Street, New York, New York 10019, before Elizabeth Willeski, RPR, of Capital Reporting Company, a Notary Public in and of the State of New York.  
Date: Thursday, June 25, 2015; Time: 10:11 a.m.
3. Videotape deposition of FRANK MUGISHA, taken by Defendants, pursuant to notice, held at the offices of DORSEY & WHITNEY, LLP, 51 West 52<sup>nd</sup> Street, New York, New York 10019, before Elizabeth Willeski, RPR, of Capital Reporting Company, a Notary Public in and of the State of New York.  
Date: Monday, June 22, 2015; Time: 10:03 a.m.
4. Email from Gina Spiegelman on October 17, 2014. List of facts disclosed to opposing counsel in response to interrogatories.

# Exhibit C



ILAN H. MEYER, PH.D.  
EXHIBIT C: LIST OF REFERENCES

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